



Investigations

Procedural Operations Manual (POM)



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* The CPS Investigations Practice Guide (IPG) is a uniform guide that clarifies the standards of CFSA social work practice for child abuse & neglect investigations. It incorporates elements of various CFSA procedures and D.C. regulations pertaining to child abuse and neglect investigations. The IPG does not, however, represent the comprehensive collection of social work practices and procedures. Therefore, CPS staff should refer to the CPS Investigations Policy, FACES.NET SDM manual for CPS, training material and federal and local child welfare legislation. As always, you should consult with your CPS management team to answer any questions and to provide further guidance.

To the CPS Social Workers:

*This guide was created for you! We hope that you find it useful in support of your day-to-day work on the frontline working with our most vulnerable and challenging children and families in the District. **Its purpose is to create clear standards and improve the quality and timeliness of practice.** Nowhere are the efforts of social workers more essential than in the protection of our children. We admire you for the important work you do and for the compassion and commitment that you exhibit each day.*

~The Child Protective Services Administration

INTRODUCTION

INTRODUCTION

The Child Protective Services (CPS) Investigations Practice Guide (IPG) is an easy-to-use reference tool for investigating child abuse and/or neglect allegations received by the Child and Family Services Agency (CFSA) Hotline. Designed specifically for the CPS social worker, the Guide provides hands-on, step-by-step procedures for giving children the immediate attention they need for their safety and protection, followed by long-range planning for their permanency and well being.

Please note in recognition that a child's biological parent is not necessarily the child's caregiver, this Guide uses the term "caregiver" inclusively to reflect the same possible relationships as cited in DC Code, i.e., "parent, guardian, or custodian".



AGENCY MISSION

The DC Child and Family Services Agency works to improve the safety, permanence, and well being of abused and neglected children in the District of Columbia and to strengthen their families. This Practice Guide is a living document that fully supports this stated mission. The role of the CPS social worker in helping to fulfill this mission cannot be underestimated!

Safety-All children have a right to be safe from abuse and neglect.

Permanency -All children need a permanent family who can provide an unconditional, lasting commitment to them.

Child and family well-being -Children deserve to grow up in nurturing environments where their physical, emotional, educational and social needs are met

GUIDING PRINCIPLES

In addition to supporting CFSA's stated mission, the Practice Guide also reinforces the guiding principles of the CPS Administration:

- **Quality & Competence**
- **Excellence**
- **Accountability**
- **Efficiency**
- **Timeliness**

Quality & Competence– High quality investigations, including safety and risk assessments, are essential for the protection of children, youth, and families. When a high quality investigation is completed, the Agency's clients are ensured the protection and safety they deserve.

§

Excellence – Excellence in service delivery is a continuous process and involves critical thinking, non-judgmental communication, professional interpersonal interviewing, adherence to policy and procedure, and the use of best practices.

§

Accountability – Sound decision-making based on policy and procedures helps to ensure accountability. Accountability is also accomplished through comprehensive assessments informed by the gathering of pertinent facts and details. Accurate and concise documentation of our decisions and the information which supports them prove our efforts.

§

Efficiency – Through use of the Agency's state-of-the-art automated child welfare information system, known as FACES.NET, you increase the efficiency of services to clients as well as the Agency's ability to track placement and permanency data

§

Timeliness – Children in need of protection also need rapid intervention to secure their safety. The timeliness and accuracy of your response, along with policy compliance will ensure the best safety intervention process possible. Equally important is timeliness in the documentation of the investigation notes. Details should be documented as soon as possible after you have gathered the information (and within 24 hours), and concerns that need to be raised to a supervisory level should never be delayed. This includes making calls from the field as needed to support your work and decision making.

As a gatekeeper for the children and families entering the child welfare system, you are bound by the above guiding principles whenever you are investigating reports of alleged maltreatment, or child abuse and neglect.

In partnership with your management team, the CPS Investigations Practice Guide will support your ability to respond to allegations of child abuse and/or neglect. It was specifically designed to function as a living document, and to evolve alongside the changing needs of the District's child welfare population. Accordingly, the Guide will automatically serve as a vehicle for implementing new evidence-informed child welfare practices while simultaneously incorporating current policy and procedures, and relevant federal and District CPS requirements. "Practice Points" are included in the Guide to further support your activities in key subject matters.

OVERVIEW OF THE

CPS ADMINISTRATION



The CPS Administration is comprised of three divisions staffed by a program administrator, program managers, supervisors, social workers, and family support workers. Although the divisions are not specifically divided by investigation type, there are specialized units (e.g., sexual abuse and institutional abuse) that serve the entire Administration.

CPS ROLES AND RESPONSIBILITIES

The more you understand the individual roles and responsibilities for each member of the CPS team, the more effective and stream-lined your communication will be and the more successful your outcomes for child safety.

Remember: the CPS teaming process is a built-in structure and support network for workers and managers to perform their assigned roles and duties.

Program Administrator

In support of CFSA's teaming principles and best practice standards, the Child Protective Services administrator is a hands-on leader who is available for consultation, feedback, and direction. In addition to providing strong leadership and oversight for all CPS field operations, the administrator establishes the core vision, goals, objectives, short and long-range plans, and any CPS administration projects designed to enhance the Agency's child protection outcomes. The administrator is further responsible for developing and interpreting both operational and program policies along with specific procedures. Although the CPS administrator ultimately reports directly to the Deputy Director of Agency programs, there is consistent and ongoing communication with other internal and external stakeholders to ensure the integrity of the CPS administration, specifically for CPS performance outcomes, future developments, evaluative procedures, and cutting-edge strategies for the protection of children, youth, and families.

Program Managers

The CPS program manager is experienced in assessment and evaluation, communication and negotiation, performance management, staff development and training, as well as the ability to provide day-to-day oversight of CPS units that provide direct and/or indirect services to and/or for children and families. In addition to providing assistance to the CPS administrator as needed, a program manager's responsibilities may include [but are definitely not limited to] handling information related to child fatalities, responding to or approving referrals when a worker is unable to contact a supervisor, as well as functioning as a liaison between CPS and both internal and external stakeholders.

Supervisory Social Workers

The CPS supervisor is responsible for supervising the full range of direct social work services provided by his or her team of social workers. The importance of the supervisory role in consulting and overseeing child safety decision-making is as important as the actual practice occurring among CPS workers in the field. CPS supervisors must make every effort to ensure that the safety and well-being of children and families is secured through the delivery of professional, high quality, competent, and timely services. The following functions are expected of CPS supervisors as part of their supervisory responsibilities:

- Set clear expectations for staff and assist with their professional development.
- Coach, support, and role model exemplary practice standards.
- Inform workers of any practice or policy changes, and give guidance as needed.
- Be available for supervisions and consultation as needed.
- Create a climate of teaming, and address the needs of staff to maintain the teaming environment.
- Model behaviors that are consistent with CFSA's mission and the National Association of Social Workers' (NASW) code of ethics.

CPS Social Workers

Child protection is the most challenging area of child welfare. As the CPS social worker, you are responsible for the referrals assigned to you, including field investigations and provision of services. You are required to determine if the report of suspected child abuse or maltreatment is substantiated and requires further action, and if so, what action is necessary. In addition, you are required to continue to assess the risk of further abuse and maltreatment of the child in the requisite time period noted in the DC Code. Ideally, the CPS social worker employs the following skill sets on a daily basis:

Family Support Workers (FSW)

The main goal of the Family Support Worker is to assist the Administration in ensuring the safety and minimized risk to any child with a suspicion of abuse and neglect by their parent or caretaker. The CPS Family Support Worker will assist in tasks across the administration that include, but are not limited to, independent visits to ensure child safety, assistance in emergency and planned removals of children from their homes into safe and secure environments and the obtaining and assessing of information that will assist in the determination of referrals alleging abuse and or neglect.

Given the close contact and sensitive nature of child protective services in general, it is important that the FSW have a clear understanding of child welfare practices, child development, and the helping relationship. The FSW is a valued member of the CPS team who performs casework under the supervision of a Supervisory Social Worker. The FSW provides a wide range of support and services for complicated cases. The FSW may provide, but is not limited to, one or more of the following key supports to CPS social workers:

- Seven- Day family visit
 - Entering documentation of the activity during the visit

- Placement of children into foster care
 - Entering of documentation of the activity during the visit
- Medical Screenings of children in preparation for placement into foster care
 - Completion and delivery of the placement packet
 - Entering documentation reflecting the activity of the placement and medical screening
- Supervision of Visits
 - Documentation of parent/child and sibling interaction during the visit
- Interviews of Supporting persons or entities to assist in the completion of an investigation
 - Documentation of all activity during this task
- Referrals for services as needed during each referral
 - Documentation of referrals made and or requested

Types of Units

CPS employees are essential and this administration is open 24 hours a day, 365 days a year. Under its current structure, CPS Investigations has four types of units to address the various allegations reported to the Hotline.

Resource needs of the CPS administration, however, may sometimes require any given CPS social worker to handle an investigation that falls outside of the social worker's particular unit. Therefore, every CPS social worker should be well versed in all aspects of child maltreatment and be able to complete all types of investigations.

Traditional Units

Traditional CPS units investigate the majority of neglect allegations. Depending upon the severity of the allegation, physical abuse allegations are also investigated in traditional units.

Special Abuse Unit

This unit investigates allegations of serious physical abuse of younger children, sexual abuse of children of all ages, and child fatalities.

Institutional Unit

This unit investigates allegations of abuse or neglect in foster homes, group homes, congregate care facilities, residential hospital facilities, boarding schools, licensed daycare facilities or homes, and/or juvenile detention facilities (including the District's Department of Youth Rehabilitation Services' New Beginnings Facility which, although located in Laurel, Maryland, is a District-run and District-owned facility). This unit also assists with sexual abuse investigations as needed.

Note: CFSA does *not* investigate assaults by staff members in schools (such as DCPS or charter schools) unless the staff members are acting in loco parentis (such as in a residential school). Concerns related to assaults that occur in schools may come through the CPS Hotline but these are forwarded to the District's Metropolitan Police Department (MPD) for investigation as assaults (*please refer to the CPS Hotline Practice Guide for referral standards*).

Afterhours Units

CPS is staffed 24 hours a day, 365 days a year. The afterhours shifts are comprised of evening and midnight shifts who rotate their assigned days of the week to include weekends. These units primarily address emergency situations but also assist the overall needs of the administration by maintaining workloads, as needed, and by completing requests for assistance from other shifts.



INVESTIGATION RESPONSE TIMES

Timely initiation of investigations is required in order to determine children's safety. The following guidelines for the assignment of response times are highlighted from the *CPS Hotline Policy*.

1. It is mandatory for all CPS investigations to be initiated as soon as possible, but no later than 24 hours after the receipt of the report.
2. If a report is prioritized for "Immediate Response", the investigation must be initiated within 2 hours of receipt of the report.
3. Initiation of investigations is considered to have been established when the CPS social worker has made face-to-face contact with the alleged victim child(ren). Good faith efforts must be made to see the child(ren) not only in the home, but in school or daycare when applicable.



Immediate Response

An "immediate response" is required when a report of suspected abuse or neglect indicates that the child's health or safety is in immediate danger, i.e., there is present danger to the child that qualifies as an emergency and requires an immediate response.

24-hour Response

A 24-hour response time is assigned to a report when there is no immediate danger or imminent risk of abuse or neglect.

Members of the CPS management team may use their discretion to issue an immediate response time when appropriate to the circumstances.

It is understood that even after good faith efforts the CPS social worker may not be able to accomplish a response within the assigned time period. In such cases, it is important that you *immediately* inform your management team and that you thoroughly document all such attempts to make contact and next steps.

IMMEDIATE RESPONSE TRIGGERS

- Children are left alone.
- Child has a serious medical condition or serious injury that requires immediate medical attention.
- There is a death of a child.
- A hospital, physician, or the police are currently holding the child (e.g., as the result of a positive toxicity screen).
- The child has been caged, bound, or is significantly physically restricted in the home.
- The caregiver has made a plausible or credible threat to seriously harm or abandon the child.
- A perpetrator who has sexually abused a child has access to the child.
- The family is living in an abandoned building, or living without essential utilities, or there are environmental hazards present that are a safety concern.
- Walk-in reports.
- The caregiver is currently or was recently violent and/or out of control.
- The caregiver is mentally ill or developmentally-disabled and cannot make a reasonable judgment about the child's safety.
- The caregiver is currently involved in dangerous criminal activity, e.g., weapons are found in the home, and/or an arrest has occurred.
- There is a history of serious maltreatment, e.g., child fatality, child removed from home, child at school with a bruise, etc.
- Caregiver or child appears suicidal or homicidal.
- The examples above are not the complete list of immediate response triggers.

Better three hours too soon, than one minute too late.

- William Shakespeare

ASSIGNMENT PROCEDURES



Every weekday morning, the CPS Review Panel is held as a formalized method of investigation distribution and review of select hotline reports. Assignment procedures are detailed below. Some Hotline reports may be flagged for a CPS Review Panel due to concerns related to whether or not the report meets legal sufficiency for a full investigation. Such reports are currently reviewed by CPS staff. On occasion, staff members from one of the six Healthy Families Thriving Communities Collaboratives may also be present. The panel may choose to override the FACES.Net Decision Tool Summary and Outcome Results, based on appropriate clinical assessment and authorization from the CPS program manager. Such reviewed referrals may not be forwarded to the investigation units or may be forwarded solely for a safety assessment. Additionally, a referral to the collaborative is a potential outcome. Decisions to screen out a referral are made by the panel and documented in FACES by a member of the CPS management team before final approval.

Child Protective Services' assignments require that social workers be available at irregular hours, always ready to perform the CPS duties of protecting children and youth. In addition to investigations, worker assignments might include linking referrals or 30-day returns. The assignment procedures below apply primarily to dayshift assignments. However, links and 30-day returns may apply to afterhours shifts.

Regular response investigations are assigned at the beginning of the dayshift on a rotating basis to the unit supervisors. Consideration is given to the number of staff in rotation in each unit. Immediate response investigations are assigned throughout the shift on a rotating basis to unit supervisors.

Assignments are made to the social worker from the direct supervisor or a member of the CPS management team and follow a rotation developed within your unit. These rotation patterns vary across units and shifts to best meet each unit's functioning needs.

Some common scenarios are described below regarding other aspects of assignments:

Regular Day Off (RDO) and Worker Leave Assignments

- When a social worker or unit is on **RDO**, there will be **no assignments**, including links or 30-day returns. These matters may be "initialed", however, by another social worker and returned to the assigned social worker for completion after he or she returns from RDO.
- When a social worker is **on leave**, but would have received a link or 30-day return assignment, the **investigation will be assigned to the unit** of that worker.

Companion Investigations

- To streamline investigations involving families in the same household and/or investigations involving the same incident, the CPS assigns these matters as "**companion**" investigations that are **assessed by the same CPS social worker or unit**. However, at the discretion of CPS management, companion investigations may be handled by separate units if there is a mixture of traditional and specialized allegations or special circumstances warrant.

Links



- When there is an open investigation on a family and a new allegation regarding this family is taken at the Hotline, a **linked referral** will be created. This streamlines the investigation process to ensure that the same worker handles all open allegations regarding a family.
- Regardless of the type of investigation, **links** are assigned to the worker involved with the family. This includes linking a traditional allegation to a specialized investigation or vice versa, i.e., linking a specialized allegation during an investigation made by a traditional unit. The supervisor of the specialized unit will assist with specialized allegations if this consultation is needed.

30-Day Returns

- CPS makes every effort to minimize duplication of investigations and services. Therefore, when a social worker has closed an investigation **within the last thirty days**, and a new allegation is received on this family, the new referral will be **assigned to the same social worker previously assigned** to the family.
- In contrast to the practice regarding links where investigation types might be combined, assignments of 30-day returns are restricted to same investigation type, e.g., specialized units will only receive 30-day returns with specialized allegations, etc.

Weekend Assignments

All CPS social workers are required to work rotating weekends.

- Only supervisors of the traditional investigations unit are assigned to weekends. Traditional supervisors will ensure that each unit member in rotation will be permanently assigned at least one investigation. Up to two additional referrals will be retained by the unit for permanent assignment.
- Staff members from the specialized units also work on the weekends. Their assignments will be addressed by their respective supervisors on the next business day. With the exception of removals, the traditional unit supervisor will not make permanent assignments to the specialized workers.
- Weekend staff members are tasked with ensuring that 24-hour contacts and safety assessments are completed for as many investigations as possible. As a result, an “all hands” approach is frequently necessary when determining work assignments. Ideally, specialized investigations will be first given to specialized workers but these may also be addressed by traditional workers.
- Specialized staff may need to assist with initialing traditional investigations to reach the goal of ensuring child safety in a timely manner.
- If social workers need to conduct removals on investigations outside of their typical unit assignments, these investigations (whether specialized or traditional) will remain with the removal worker.

Holiday Assignments

- All CPS social workers are required to work at least one holiday during the year.
- Social workers do not retain permanent assignments from the holiday shift, unless they have a removal.

Removal Assignments

- At times it may be necessary for a social worker to conduct a removal pertaining to a family

that may also be the subject of a link or 30-day return to a different social worker. In these instances, the two social workers must coordinate efforts to best serve this family.

- If the non-removing social worker has information pertinent to the removal and/or services for the family, they should attend the Family Team Meeting,¹ confer with the Assistant Attorney General (AAG), and attend the initial hearing (along with the removing social worker). This worker will also be responsible for completing the investigation.
- If the non-removing social worker has not yet met the family or does not have information pertinent to the removal or services for the family, consideration should be given to reassigning the investigation to the removing social worker. This decision will be made jointly between the supervisors of the respective social workers.

Management Assignment Discretion

- In the best interests of children as well as CFSA employees, CPS management at all times retains the discretion to make assignment decisions through a panel review based on a variety of relevant factors, including the need for “new eyes” on an investigation or the availability of staff and/or resources.

¹ For more information on FTM, see the CFSA Family Team Meeting policy.

Additional Information on Referrals

At times, a reporting source will provide the Hotline with additional information on referrals and/or cases that are already active with CFSA. When this information does not rise to the level of a new abuse or neglect referral, the information is forwarded to you via e-mail by Hotline staff. This new information should be explored and your findings documented in your investigation notes.

INVESTIGATION TRACKING How can this section be simplified? Is somewhat cumbersome ~KFL

Investigations at CFSA are tracked by the biological mother's name. This has several implications for practice and there are a few exceptions.

- If the biological mother's name is not known at the time of the Hotline report, the investigation name will be "Unknown." It is your responsibility to change this to the correct name once the identity of the biological mother is learned.
- Please note that tracking the investigations in the biological mother's name does not automatically indicate that the mother is the maltreater. Please do not presume the mother is the maltreater based on the tracking mechanism!
- If there are alleged victim children in a home who have different mothers, there must be separate investigations for the children under each mother's name. These are called “companion investigations.”
- At times you will deal with a mother who is a minor. This minor (sometimes referred to as a “junior mom”) may or may not be the legal caregiver for her child, and therefore any investigation involving the neglect or abuse of her child may be tracked in her name. Any questions about her legal custody can be confirmed via the domestic relations court. If the “junior mom” resides as a minor with her own caregiver, you must determine whether that said caregiver is acting *in loco parentis* for the junior mom’s child. If there are allegations against said caregiver, they are still tracked in the investigation under the junior mom’s name. If said caregiver is alleged to also neglect or abuse his/her own children (possibly including the junior mom), this would be a separate companion investigation.
- Please note that we can substantiate allegations regarding a child by the parents, guardians or custodian who are under 18 years of age. We can and should still open a case when appropriate.
- If the biological mother's rights have been terminated and the child has been adopted, the investigation will be tracked by the adoptive caregiver's name, regardless of the alleged maltreater. Guardianship and legal custody matters generally do not involve termination of parental rights (TPR) and therefore are still tracked in the name of the biological mother.
- If the biological mother's rights have been terminated and the child has not been adopted, the investigation will be tracked based on the circumstances of the allegations. The decision will be made by the Hotline supervisor or a member of the CPS management team.
- If children are maltreated by a placement provider or other individual in an institutional setting, as defined by the CFSA Investigations Policy, the investigation will be tracked in the name of the organization that is the subject of the investigation.

FOUNDATIONAL CPS SKILLS

FOUNDATIONAL CPS SKILLS



THE HELPING RELATIONSHIP

"The potential value of a sound relationship base cannot be overlooked...the relationship conveys interest in and acceptance of the client as a unique and worthwhile person and builds sufficient trust..."

(Cormier and Cormier)

It is important that every CPS program manager, supervisor, social worker, and family support worker understand the importance of building the helping relationship and maximizing existing strengths as well as developing new ones. The "Core Conditions of the Helping Relationship"² include respect, empathy, and genuineness. These are the essential conditions for laying the foundation for **engagement**, and for developing any professional helping relationship. Regardless of your title, when you project these attributes as you intervene in the lives of families, caregivers and children, you provide an opportunity for everyone – yourself included - to experience a sense of "being understood" and valued. The natural outcome is a relationship where both parties are more willing to engage in helping one another as well as themselves.

² Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103

Respect, Empathy, and Genuineness

These are the 3 core attributes that you must project in order to develop relationships with families and to help them get their needs met while promoting safety for their children.

Respect - "...valuing another person because he/she is a human being. Respect implies that being a human being has value in itself."

When you **display respect** you show that you believe that human beings are worthy of respect, you understand the uniqueness of each person, and you believe that people can change.

When you **communicate respect**, you accomplish the following positive goals:

- Reinforcing caregivers' strengths.
- Communicating warmth.
- Suspending critical judgment.
- Demonstrating commitment.
- Developing empathy.

Empathy – "...the process of tuning into (feeling) another person's feelings, developing a sense of what the situation means to and feels like for the individual, and communicating understanding and compassion to that person. It is in the nature of empathy that we build a bridge between ourselves and others."

You display empathy when you develop the following skills:

- Tuning into another person's feelings.
- Communicating compassion.
- Expressing your desire to understand.
- Learning what is important to the family.

Genuineness - “...involves being aware of one’s own feelings and making a conscious choice about how to respond to the other person, based on what will be most helpful in facilitating communication and developing a good relationship.”

Expressing genuineness includes the following positive actions:

- Being yourself.
- Remaining non-defensive.
- Matching your verbal and nonverbal behaviors.

Each of these core attributes is critical for reinforcing the helping relationships between CFSa staff as well as with our clients and external stakeholders. When embarking on any investigation, check yourself on each of these three attributes, so that you can be your best professional self when engaging with families.

OBJECTIVITY

Objectivity is the principle of examining situations without bias. As a CPS social worker, you must be objective enough to systematically evaluate clients and their situations in an unbiased, factual way.

THE IMPORTANCE OF OBJECTIVITY	
Throughout the investigation process it is very important that you remain OBJECTIVE. To maintain objectivity throughout the CPS response, you should consider the following requirements:	
✓	Be aware of your own values, beliefs, feelings, and needs, and consider their influence on your perceptions.
✓	Pay careful attention to detail when making observations.
✓	Conduct an open, systematic search for facts before drawing conclusions.
✓	Practice consistency in your decision-making; following policy and procedures over emotion

UNDERSTANDING AND ENGAGING THE FAMILY SYSTEM

Families often become involved in the child welfare system because of disturbances in the family system, usually due to changes in the larger environment and/or within the family itself. In order to assess safety and assist the family, the assessment must be made within the required response time. When you respond according to the response time noted on the referral, it allows you to accurately determine whether there are any safety factors that place the child in immediate danger or impending danger. During the assessment you will examine and evaluate the home conditions, and you will interview and observe all of the children in the household, including the alleged victim, parent or caregiver, alleged maltreater, and all other household members.

Finding a CPS worker at the door almost always arouses discomfort and undermines emotional security, as well as threatens the family's balance. When conducting an investigation of reported child abuse or neglect, the best way to start any interview is by **engaging** the alleged maltreater, caregiver, or family member.

Engagement is the process of connecting with the child/youth, mother, father, extended family, primary caregiver, and other team members for the purpose of building an authentic, trusting, and collaborative working relationship.

When you “engage” with a family, you actively work with them to promote safety, permanency and well being for their children. To be successful, you must also embrace the core conditions of the helping relationship: respect, empathy and genuineness and you must embrace the following key elements:

- Active listening to each family member.
- Developing an understanding of the family's past experiences, current situation, concerns, strengths, and potential.
- Responding quickly to a family's concrete needs.
- Clearly establishing the purpose of involvement with the family.
- Being aware of one's own biases and prejudices about families.
- Validating the participatory role of the family in planning and making decisions for their child.
- Being consistent, reliable, and honest with families.
- Fully disclosing information with families.
- Honoring the culture, racial, ethnic, linguistic, and religious or spiritual backgrounds of children, youth, and families, as well as respecting differences in sexual orientation.

Engagement

- Remember the core conditions of the helping relationship in all of your interactions with families.
- *CPS social workers should never read the allegations as they are narrated on the referral.* Reading the allegations word for word may place the reporter and/or the children at risk of harm. You may also miss critical information by focusing on specific incidents when a broader conversation would yield a truer picture of the family situation.
- Remember, all members of the household must be interviewed alone and separately. This process allows you to gain individual explanations of the allegations on the referral to gather information about the presence of safety factors and to assess for evidence of any abuse or maltreatment. Adults must be interviewed separately to ensure that they are not influenced by others and that their individual voice is heard. Children must also be interviewed separately for the same reasons, including from the caregiver/alleged maltreater as well as any other children in the home.
- Later in the assessment it may be of use to interview adults and/or children together to be able to observe their interactions or to jointly plan for the family.

Engaging Challenging Clients

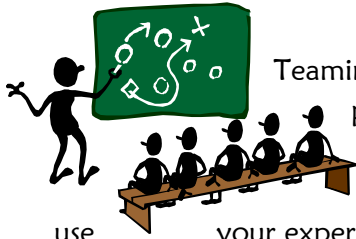
In all probability, a certain subset of your clients will become upset, hostile, verbally abusive and/or threatening. These individuals can be caregivers, relatives, youth or even professional members of the community. When handling a difficult conversation or phone call, the key role you are expected to play is one of a calming influence so that you can gather the pertinent information that will help to protect (or save) a child. The following popular strategies are useful for minimizing an angry or verbal attack from a client:

- 1) **Simple Listening:** Wait until the person is finished talking. Listen and wait for him or her to take a breath, and then ask a directed question, such as "What can I do to help you?" Your tone should be determined, not placating.
- 2) **Active Listening:** Make a genuine attempt to put yourself in the other person's situation as best you can. Listen to what is *not being said* as well as the words that are expressed. Identify the underlying emotions.
- 3) **Acknowledgement:** Respond honestly – and respectfully - when you calmly acknowledge the person's position. You might say, "I can see how something like that could cause some anger." or "If that happened to me, I would be angry, too." This confirms the legitimacy of the emotion, but it also diffuses the approach the caller has taken to communicate the intensity of the emotion.
- 4) **Apologizing:** Sincerely apologizing for anything in the situation that you recognize as problematic is not the same as taking the blame. You can always say, "I'm so sorry that happened to you" or "I'm sorry the situation is so frustrating." This allows the individual to

feel that they are not alone, that you identify with them in the particular circumstance, and that a certain measure of trust can be invested in you as the worker.

- 5) **Agreeing:** There are usually three truths to any given situation – your truth, the other’s truth, and THE truth. It is important to listen for THE truth. Agreeing with the truth of a situation can help redirect the interaction towards a productive outcome.
- 6) **Inviting Criticism:** Sometimes it is effective to invite the client to get their criticisms out in the open. You might say something like, "Go ahead and tell me *everything* that has you upset. Don't hold anything back. I want to hear all that you have to say." It may seem at first that this strategy intensifies their emotional state but eventually, the distraught person will expend themselves and you will have the opportunity to continue gathering necessary facts.

TEAMING



Teaming is the foundation of the District’s child welfare practice and a core component of your practice when addressing child abuse and neglect. By teaming with the family and other team members, you will gain the advantage of genuine collaboration during case planning and decision-making. As a CPS social worker and licensed clinician, you must use your expertise and practice wisdom to work with families in ways that encourage them to fully participate in the assessment, case planning and other key decisions involved with CPS intervention. Remember that your efforts are more likely to succeed when clients are involved and actively participate in the process.

Key Outcomes of Effective Teaming:

- Children/youth and families benefit from active involvement.
- Collaboration supports sound decisions and coordinated, effective services.
- Children/youth achieve permanence promptly.



When you team with the family, you allow the child (when developmentally appropriate) or youth, birth parents (including non-custodial parents), extended family, and caregivers to participate in decision-making regarding safety, permanence, and well being.

As a joint process between the entire family and other professionals, the team’s insight becomes a part of the CPS assessment. As the CPS social worker, you will team with families during the FTM process, and you may also team with the non-offending caregiver in developing a safety plan. You may team as well with a teen in the home around what they believe their family needs, as well as external professionals. Keep in mind, that when you team with the family, you improve their chances for successful outcomes!

BASIC INTERVIEWING

The interview is the primary method used to gather information from the children and families that you will meet in your work. In fact, your ability to perform your primary responsibilities depends in large part on your interviewing skills. During your initial contact with the family, your goal is to obtain and assess select information to make informed and effective decisions on behalf of the children, and to help develop an appropriate set of interventions. The CPS interview can be a very difficult part of your involvement with families. The core helping conditions of empathy, respect and genuineness will support you throughout this important process.

Introduction:

When beginning an interview with a caregiver, it is best to start broadly before narrowing in on the allegations. For example, begin the conversation by introducing yourself and explaining the reasons why you are there to speak with them:

“My name is [...] and I'm representing the District of Columbia's Child & Family Services Agency. I am here because there are some concerns about the safety of your child(ren). The reason for my visit is to make sure you and your children are safe, and if necessary, to assist you and your family in keeping them safe. To do this I need to ask you some questions about your children and family. Please know that I will carefully listen to whatever you have to say. You can also tell me of any concerns you have.”

During the introduction, explain both the philosophy of CPS and your obligation to conduct a comprehensive investigation on the well-being of the family. This will justify your request for certain information, particularly when you ask to see children who may not be the direct subject of a report. For example:

“When we receive a report from the Hotline, part of what we do in CPS is check on the safety and well-being of everyone in the family. That means I need to talk with you about the basic things you do as a caregiver, for example, feeding and clothing your family, maintaining the household, and so on. I also need to learn about supervision and discipline of the children, and so forth. Afterward I'll need to talk with your children individually to hear their thoughts about your family.”

Remember that your conversation with the alleged maltreater (or non-offending parent or caregiver) is about getting to know the family dynamics and how the family functions as a whole, not just one specific level. Many times you will address the allegations through this introductory, general conversation.

It is important to avoid accusatory language that may instigate or elevate tension. Try to use words like “concerns” or “questions” rather than “allegations”. Later in the interview you may have to be more direct in your questioning but the initial process should take place with a conversational tone.

Special Note: not all standards work with every client. *That is why interviewing is more art than science.* If you are dealing with a hostile client or a client who is fixated on the allegations, you may have to begin with direct questioning to make any progress in the investigation. Either way, use your engagement and conflict-resolution skills. Hopefully, you can develop a collaborative dialogue as you continue the interviewing and investigative process.

REMINDER: YOU CANNOT REVEAL A REPORTING SOURCE!

If the caregiver insists on knowing the reporting source, be prepared to redirect the conversation. Explain frankly to the caregiver the legal reasons why you cannot share this information. Use empathic language:

“It’s reasonable for you to wonder where this report came from. If I were you, I would want to know as well but because of the rules I have to follow, I can’t confirm or deny the reporting source. It’s just a legal fact that people who contact CPS have the right to remain anonymous. I do know, however, that sometimes people don’t know the whole situation or make false reports. You can imagine that the reporter might fear retaliation so they need to know that they can safely report legitimate concerns. That’s why it’s so important for you to have this opportunity to share your information with me and for me to keep an open mind when I come out to investigate. We don’t know what is true without talking with you. So I’m hoping we can sit down together and sort through this report. The most important thing is the safety of children.”



Key points to remember:

- When you show up at the door, you will likely be unwelcome. You must work hard to build rapport and engage the family in the interview process.
- Determine the caregiver’s understanding of the purpose of the interview.
- Ask for his or her questions or concerns.

Engagement:

After you have introduced yourself and explained the reason for the interview, you can begin to build rapport with the family member and gather the information you need to assess the safety of the children. Ask general questions about the family. *If there is more than one caregiver, is important to interview each caregiver separately and also to compare the answers of all family members.*

Key points to remember:

- Pay attention to the emotional state of the family. Family members experience a variety of powerful emotions and may express their anger, fear, and frustration during the interview. A highly-charged or emotional family member may not be able to provide clear and detailed information. Show your concern; this often helps to decrease the level of tension.

Free Narrative:

When it is time to discuss the allegations, remember to avoid accusatory language. *Do not read the allegations described in the referral snapshot.* Start by asking questions that will allow the caregiver to have an opportunity to provide his or her own version of the events:

“So I'm here because of some concerns about your children that were brought to the Agency's attention. I'd really like to hear your thoughts about how things are going with your family. We'd also like to offer assistance if there is something we can help your family with.”

At this stage of the interview, avoid interrupting the caregiver's account of the circumstances. Allow them to respond at their own pace, and you can ask follow-up questions afterwards.

Let the caregiver talk about what is important to them. They will likely tell you significant information about their thoughts and feelings on the family even if you do not immediately get to the heart of the allegations. Your ability to listen and acknowledge what is important to your client provides a foundation to move into more specific conversation about the allegations.

Open-ended Requests and Questions:

Once the caregiver has had an opportunity to express their thoughts on why you are investigating the family, you can begin exploring the allegations by asking open-ended questions and/or requesting information. Do not directly identify the allegations as described in the intake report. Rather, start with generalized questioning.

EXAMPLES OF APPROPRIATE VS. INAPPROPRIATE QUESTIONS

APPROPRIATE	INAPPROPRIATE
“Please share with me your understanding of how your daughter was injured.”	“So tell me, why did you punch your daughter in the eye?”
“How is your child doing in school? Does your son or daughter enjoy school?”	“Why is your child falling so far behind in school? How come your child is in danger of repeating a grade?”
“How is your child's school attendance?”	“This allegation says you do not send your child to school.”
“Let's talk about the use of alcohol.”	“It looks to me like you have a drinking problem.”

Specific Questions:

It is important to realize that some people do not view their actions as maltreatment and most people do not readily admit to mistreating their child. **Reminder:** denial of an allegation does not automatically mean that

the allegation is not true, nor does it imply that there are no legitimate safety concerns for the child. To gather as many facts as possible, it may be necessary to ask very pointed, specific questions regarding the allegations. You may need to be equally specific when requesting information that will influence your overall assessment. How and when you discuss or describe the nature of the allegations will be determined based on the circumstances of the investigation, the family circumstances, and your own judgment.

Concluding the Interview:

A respectful conclusion to the interview builds trust and opens the door for ongoing or future engagement opportunities with the caregiver. Always give the client an opportunity to ask questions. Always thank him or her for taking the time to speak to you, and remember to provide your contact information.

All essential information has now been collected, and as many gaps as possible have been filled, including information on demographics and family composition. At this stage, you will give the individual an opportunity to share any additional information that may not have been revealed during the Exploratory Stage of the interview.



Key points to remember:

- Summarize the key points, decisions, and any additional information that have been discussed.
- Ask the individual if they have any questions, and respond honestly and directly.
- Discuss future actions and next steps.

GENERAL CONSIDERATIONS FOR CPS PRACTICE

PHILOSOPHY OF COMPREHENSIVE INVESTIGATIONS

When CPS staff accepts an investigation regarding a family, we accept a “special relationship” with them which involves teaming to support the safety, wellbeing, and permanence for the children and the family overall. To this end, CPS involvement is not solely allegation focused; rather it is focused on carrying out the agency mission.

CONFIDENTIALITY



DC Code §4-1303.06 states that "information acquired... which identifies individual children reported as or found to be abused or neglected or which identifies other members of their families or other persons or other individuals shall be considered confidential."

Further, according to the Code, this information may only be released or divulged for the following reasons:

- purposes relating to the identification of abuse or neglect
- identification of service needs or resources
- securing or provision of treatment or direct services for the child or individual identified
- the investigation or review of child fatalities by representatives of the Child Fatality Review Committee

Additionally, the Code notes that "persons or agencies who are not covered by confidentiality requirements comparable to those [above], to whom information is released pursuant to this section, must sign a statement that they will not divulge such confidential information for purposes unrelated to the purposes of treatment, identification or evaluation."

You must always exercise discretion when sharing information for the purposes identified above. In general, information should be shared on a "need to know basis" for the purposes discussed. If you have questions, please consult your management team or the General Counsel's office.

In many areas of investigative work, you will find that you have the ability to ask questions of and receive information from collateral sources. You must recognize that you may not always be able to, or need to, share information in response. Acclimate yourself to this concept and be able to comfortably discuss this with individuals. Many people will still be willing to share information with you once they understand the boundaries within which you have to operate.

In general, you cannot confirm or deny that the Agency has involvement with a given child or family. If collateral sources of information reach out to you without proper releases of information, you may accept information from them and explain that if the Agency is aware of this family, the information will be forwarded to the assigned social worker and management team. You may, at times, determine that information sharing is warranted with certain collateral sources but you should take care to obtain proper releases (*Authorization to Disclose Information*) of information whenever possible, even though this may not be a legal requirement. If you are not able to obtain releases of information,

and information needs to be shared for the purposes discussed above, you must limit this sharing information that is absolutely necessary.

Biological Parents Who are Not Primary Caregivers

Biological parents usually have a right to information on CPS investigations involving their children, provided that their caregiver rights have not been terminated.

Provided that you have properly identified an individual as a biological parent whose rights are intact, you may share information about the investigation with this individual. You must still exercise discretion when sharing the information, ensuring that it follows the provisions discussed above. One person's information may not be able to be shared with another person, but information concerning their child in common would be. However, information on a half-sibling should not be shared with the non-legal guardian or custodian.

Specific care should be used when sharing information with a parent who is not a primary caregiver or who may have a level of hostility toward, or estrangement from, the primary caregiver. You should realize that at times, information sharing might jeopardize the physical or emotional safety of a child or other individual. This must be considered prior to disclosing information. For example, a secondary parent may be entitled to information on the disposition of whether their child has been abused or neglected, but they may not be entitled to the details of how that determination was made, including demographic information and so forth. When in doubt, you should consult with your management team about confidentiality concerns. You may also wish to consult with the CFSA Privacy Officer.

Neighbors



Neighbors can be a vital source of information for your investigation. You are allowed to speak with neighbors but you are not allowed to reveal that you have an investigation on a given child or family, as this breaks their confidentiality. You may explain to neighbors that you would like to speak with a given child or family but you cannot give any detail as to the reason for such contact. You may explain to neighbors that your job is to protect children and that they may talk with you about any concerns they have regarding the well-being of any child, including the ones about whom you may have directly asked.

If you receive information from neighbors that is critical to the investigation, talk with them about their willingness to share their name or contact information and whether they are willing to be witnesses to this information. If they are not willing to share their information in an official capacity, you should respect this. You are still able to document their concerns in FACES (as an anonymous source) and use this toward your overall decision-making and disposition if you believe the source of information is credible (*see definition of “credible evidence”* in the appendix).

Extended family

For investigations that do not involve a removal, extended family do not have a right to information about the investigation. If you are contacted by extended family, you may receive information from them but cannot share information (unless it is related to the purposes discussed in the introduction

to this section). You cannot confirm or deny involvement with a given family without proper releases of information. Remember that many extended family members care deeply for the children and families about whom they may be contacting you. Empathize with their concern.

There are times when you will be able to communicate with extended family with proper consent from the parent or caregiver. This consent should be in writing for the protection of all parties. In these situations, this communication should still be handled thoughtfully, on a “need to know” basis. The only information shared should be that which is related to the planning for the family safety and well-being, and even then, only the components that involve the extended family.

In removal situations, you are able to share with extended family that a child is in CFSA custody. Without a proper release of information, you are not able to share any reasons why the child is in care. You may talk with family members in general about CPS processes and also receive information from family members that may be critical to the investigation. Family members should be informed of the Family Team Meeting (FTM) process but also should be made aware that the legal caregivers give consent for extended family to be invited to this meeting. Family members may be informed of the initial court hearing and, if the judge permits, may be present in the hearing to become aware of the circumstances of the removal.

Multi-Disciplinary Team (MDT) Partners

The multi-disciplinary team was established for the purposes of improving service provision to victims and family and enhancing legal responses to child maltreatment. Therefore, you are able to share information with our MDT partners about investigations for the purposes discussed in the introduction to this section.

Service Providers



As noted in the introduction to this section, you may share information with individuals who may be providing services to a child or family. The information you share must only be related to the service provision need, however, and should not fall outside of this scope. Whenever possible, obtaining an appropriate release of information is preferred.

Custody Court Personnel

You are prohibited from sharing information with custody court personnel, including judges, without express permission from the CFSA Office of the General Counsel (OGC). If you are approached for information in a custody proceeding, you must explain that you cannot confirm or deny involvement with a family and refer the individual requesting information to the OGC.

Talking to Individuals Represented by Counsel

While not expressly related to confidentiality, you must be prepared to speak with individuals who are represented by counsel, be it in a family court matter or some other court proceeding. Counsel for an individual can express to their client that the client should not speak with you without representation. It is still up to the client to make a decision as to whether they will adhere to this. You are not required to speak with clients through their counsel and should not feel compelled to do so. Your function is to assess for child maltreatment and to coordinate an appropriate professional response to the concerns identified.

CULTURAL AND LANGUAGE CONSIDERATIONS

With every CPS investigation and assessment, a person's history and culture may affect certain areas. As a CPS social worker, it is important that you gain an understanding of each family's culture. You must also recognize that a given culture cannot be defined simply as a static bundle of fixed traits. The following questions may be used as part of the assessment to guide your understanding of cultural differences.

- What roles do males and females play in the family?
- What is the role of religion for the family?
- How do the family's beliefs influence child-rearing practices?
- What is the meaning, identity and involvement of the larger homogeneous group (e.g. race, nationality)?
- What family rituals, traditions and behaviors exist?
- What is the usual role of children in the family?
- What is the perception of the role of children in society?
- What types of discipline does the family consider to be appropriate?
- What are the family's attitudes or beliefs regarding health care?
- What are the family's sexual attitudes and values?
- Who is assigned authority and power of decision making?
- What tasks are assigned based on traditional roles in the family?
- What are the communication styles in the family?
- How does the family solve problems? Deal with conflicts?

A culturally sensitive CPS assessment recognizes caregiver practices and family structures vary as the result of ethnic, community and familial differences, and this range can result in different but safe and adequate care for children within the parameters of the law. The CPS assessment process must acknowledge, respect and honor the diversity of families.

The following are examples of cultural practices which are considered unacceptable (but this list is not exhaustive):

- **Coining-** a "medicinal" folk practice that involves the rubbing of heated oil on the skin, most commonly on the chest, back, or shoulders, and then vigorously rubbing a coin over the area in a linear fashion until a red mark is seen.
- **Cupping (or cupping method)** - a "therapeutic" method involving the application of suction by placing a vacuumized (usually by fire) cup or jar onto the affected or any part of the body surface.
- **Female Circumcision (or female genital mutilation [FGM])**-this practice comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.



LANGUAGE CONSIDERATIONS

The investigation process for every referral must accommodate individuals who have a limited ability to communicate in English, either because the individual speaks a foreign language or because there is sight, speech, and/or hearing impairments.

Limited English Proficiency (LEP) may impact the parent, caregiver, the children in need of protection, the alleged maltreater, other members of the household, key collateral contacts, other relatives who may need explanations of the investigation process, the investigation findings, and/or the outcome of the investigation.

Every client with LEP has the legal right to understand, as fully as possible, all significant CPS actions at each stage of the investigation process and service, including but not limited to the following investigative procedures:

- investigation of the allegations of child abuse or neglect
- adverse actions such as removal of a child from his home
- case planning and service delivery
- judicial proceedings in which the court does not itself provide bilingual or interpreter services
- the right to a fair hearing and the appeal proceedings
- the administrative review process

*It is your obligation as the CPS investigative social worker to make reasonable efforts to provide information and services in a language or medium that the client can understand through the use of interpreters, translators, readers, or other methods. **You must offer a translator or other communication support for every visit.*** If the client declines such services, please have them sign a statement indicating such and include it in your record.

Note: Your efforts to provide bilingual or interpreter services must not delay or interfere with either of the following necessary actions:

- protecting a child from harm or risk of harm
- compliance with all federal and local laws, rules and regulations

Language Access Line Services

Language Access Line Services give you access to over-the-phone interpretation 24 hours-a-day, seven days a week. This program ensures that clients with LEP will have access to the services they need while simultaneously providing you with the support you need to deliver those services.

Every CPS investigator is required to take the Language Access Line training.

When you first become aware of the need for language line services (e.g., at the onset of an investigation, you realize a witness to an allegation cannot be interviewed without the language access line service), or when you are placing a call to a client with known LEP, you should adhere to the following procedures:

1. Dial 1-866 874-3972
2. When the language line representative answers, provide him or her with the following information (or enter the information on your telephone keypad according to the prompts):
 - Enter the 6 digit Client ID: XXXXXX
 - Provide our Agency's name: DC Child and Family Services Agency
 - Press 1 for Spanish.
 - Press 2 for all other languages (be prepared to state the language that needs to be interpreted).
 - Enter the secured Access Code: (this number is received during training).
3. Once the interpreter is connected to the call, provide the following information:
 - Brief the interpreter regarding the purpose of the call.
 - Summarize your objectives and goals for the conversation.
 - Provide any additional or special instructions.
4. Lastly, connect the client or individual with LEP to the line.

NEVER use family members, friends, or child victims as translators! Even with consent of the party, this is inappropriate.

CPS does not use family members, friends, or children (including child victims) to interpret, translate, sign, or read for clients with LEP. A Metropolitan Police Officer (MPD) if present and who speaks the same language as the client may be used to translate for brief interactions that specifically assist a client's request and/or arranges for the requested translation services. Ideally, interpreters and translators will be professionally trained and/or be a CPS staff person who is fluent in the client's preferred language. Some MPD officers are certified and can be used as an interpretation resource.

Ensuring Comprehension of Written Material

Notwithstanding LEP status, a client may have a limited ability to understand material written in his or her own language. When communicating your purpose, goals, and services to a client, you should verbally review written material with the client and the interpreter to ensure that it is fully understood.

Removal Concerns

If you must remove a child from his or her home, you must consider the child's language needs and assess the importance of placing the child with a foster family that speaks the same language. Language is not the only

factor to consider in placing the child, but it must not be neglected. You must ensure that any LEP needs are communicated to the Placement Services Administration.

If the parent or caregiver speaks a language other than English, you must document the language on the complaint form and in FACES to ensure that the Family Court will obtain a translator and assign an attorney who is appropriate for the client during all court hearings.

Documentation

You must carefully document in FACES:

- any offer of an interpreter to assist in translation for a client (whether the client accepts or rejects the offer)
- when the use of an interpreter occurs
- the interpreter's name (e.g., the Language Access Line) or agency affiliation (e.g., staff at CFSA)
- the interpreter's relationship (if any) or professional affiliation with the person with LEP
- use of any type of communication aids
- your own ability (or inability) to communicate in the client's preferred language
- any reason why an interpreter might not have been used

PROTOCOL FOR DETERMINING A CHILD'S BIOLOGICAL OR LEGAL CAREGIVER

Biological parents

Every child has two biological parents and neither should be overlooked in your investigation. You must exercise care, however, in determining the identity of biological parents and make effort to obtain names, address, telephone number, and nature of parent's relationship with the child.

For most investigations, the biological mother will be known but there may be times when the maternity is questioned. When this occurs, you should seek out guidance from your management and legal team.

In contrast, the identity of the biological father may not be legally obvious during many investigations. For the purposes of CFSA involvement with families, a man may be considered the biological father under the following circumstances:

- He was legally married to the mother at the time of the child's birth.
- His name is on the child's birth certificate.
- Paternity testing has been completed and demonstrates that he is the father.

- Court paperwork (paternity affidavit, child support documentation, etc.) exists reflecting that he is the father.

Whenever you face a question of maternity or paternity, you must view legally appropriate paperwork to show that the individual in question is in fact the biological parent. It is not sufficient to simply hear that someone is named on a birth certificate or to see unofficial paperwork suggesting that an individual is a parent. You must see the actual birth certificate yourself. Examples of unofficial paperwork might include a person's name as the parent on a permission slip for a school field trip, or a person's name on a note excusing an absence from school.

Legal Caregivers

Many families make informal (or formal) living arrangements for the care of children, which may be perfectly acceptable. Regardless of such arrangements, you are required to be aware of and in contact with a child's legal caregiver whenever you engage with a family. You must also exercise care in situations where you are responsible for releasing a child to a caregiver (e.g., a child who is not picked up afterschool and presents to CPS for assistance). *You may not release a child to a non-legal caregiver.*

You must verify a child's legal caregiver through the following documentation:

- Legal paperwork that proves the legal caregiver was changed through Agency involvement that resulted in a new legal custody, guardianship, or adoption relationship.
- An order from an established court of law granting physical custody of the child to the individual.

INVESTIGATIONS INVOLVING OTHER JURISDICTIONS

If the maltreatment occurred in another jurisdiction, but the family or children reside in the District of Columbia, you must complete the following tasks:

- Conduct an investigation to determine where the alleged maltreatment occurred.
- Make a report of the alleged maltreatment to the jurisdiction where it occurred.
- Conduct a courtesy interview and home visit if requested by the other jurisdiction.
- Consider whether an investigation or safety check is warranted in the District given the overall mosaic of the family. This decision will be made in concert with your management team.
- Under no circumstances may you close an accepted CPS investigation without verifying the whereabouts of the alleged victim children and family and ensuring that a CPS professional has made contact with them.
- Consult with CFSA's Office of the General Counsel for legal advice as needed.

If the maltreatment occurred in the District but the family lives or is visiting in a nearby jurisdiction you have conditional ability to enter that jurisdiction to visit the family. The following must be considered and any questions should be directed to your management team or the General Counsel's office:

- You may visit a child or family in another jurisdiction to ensure that you have physically met and interviewed required parties to the investigation.
- You may NEVER physically remove a child from another jurisdiction.
- If, when visiting another jurisdiction, you encounter safety concerns those must be immediately reported to that jurisdiction's CPS and/or police department.

INABILITY TO IDENTIFY OR LOCATE A CHILD OR FAMILY

Per Administrative Issuance CFSA-08-2 *No investigation will be closed solely on the grounds that the child could not be located* until *thoroughly good faith efforts* have been made by the CPS worker to locate the child and family. If the child or family cannot be immediately located, investigative efforts must be elevated and the following steps taken concurrently with a sense of urgency to thoroughly exhaust all avenues for locating the child and/or family:

- A *minimum* of three (3) unannounced home visits at different times within a 48 hour timeframe with at least one visit between the hours of 8pm - 8am
- Use of Internet search engines such as <http://www.whitepages.com/>,
- <http://www.zabasearch.com>, and <http://www.freeality.com/>
- Mailing of a certified letter, in the family's primary language, to the last known address, referral address, or address listed on the ACEDS and/or SPIS report
- Contact with the reporter to obtain additional information on locating the child and family
- Visit to the child/ren's neighborhood school or school if enrollment is known (or a request should be made to the DCPS Penn Attendance Intervention Center (202-541-6411) or Douglass Attendance Intervention Center (202-698-2461) if enrollment is unknown); *efforts should also be made to reach the emergency contact person on file with the school*
- Contact with the Metropolitan Police Department (MPD) Truancy Officers to request assistance in gaining access to family (when allegations warrant and there has been involvement with the family)
- Request that MPD check their database for any involvement with the particular family or address
- Criminal background search of any known family members for access to addresses or other contact information
- Referral to the Diligent Search Unit within 1 week if family has not responded and follow-up on the results of diligent search; *No report shall be closed without receipt and follow-up on diligent search results*
- Interview neighbors, relatives, and other collateral resources
- Confirm that the family is no longer residing in the residence (via landlord, property records or verified alternative residence)
- Contact the Healthy Family Thriving Communities Collaboratives to determine whether the family is known to them or has received services from them (see attachment)
- Consult with Assistant Attorney General (AAG) staff to determine if Pre-Petition Custody Order is warranted
- Check with other governmental agencies for possible involvement, including the Department of Mental Health, the Department of Human Services, Income Maintenance Administration, etc.

FAILED ATTEMPTS FOR INITIAL CONTACT

An investigation is considered initiated when the alleged victim child (ren) have been seen and assessed and appropriate safety planning has occurred with the caregiver. At times there will be credible locating information for the family (address, school, etc.) but successful contact does not occur for any number of reasons.

Per Administrative Issuance CFSA-08-2 “Immediate Requirements for All CPS Investigations” If the family is not at home, the following steps must be completed by the CPS worker:

- Leave a notification letter in the family’s primary language (if known) at the home, requesting contact within 24 hours. **(only for neglect reports)**
- If the child is school age, make contact within 24 hours to interview the child at the neighborhood school or the school listed in the referral
- If the child is not school age, make contact within 24 hours to interview the child at the daycare center listed in the referral
- Interview neighbors, resident managers, or landlords to confirm the address or determine the whereabouts of the family. If family is no longer residing at the address, obtain a forwarding address when possible
- Conduct at least 2 additional home visits at different times with one of these visits taking place between the hours of 8pm - 8am
- Send a certified letter

CLIENT REFUSAL TO ACCESS A CHILD, FAMILY, OR HOME

You will encounter occasions when you are aware of the location of a child or family but cannot access aspects of the family situation typically required for a complete CPS investigation (including interviews of the alleged victim, siblings, household members, caregivers, or living spaces). Listed below are strategies for common scenarios. In addition, these matters should be discussed in with your management team and during the 18-day review process to ensure that all possible steps are taken and to make joint decisions, at times, that a typically required investigation component will not be required.

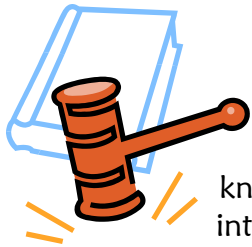
You should complete the steps discussed above for unable to locate clients, if applicable, in addition to the following required steps from Administrative Issuance CFSA-08-2.

If the family refuses to cooperate, the CPS worker must complete all of the following as appropriate:

- Contact CPS Management team immediately
- Contact MPD for assistance

- Contact the OAG – CPS section attorneys (the AAGs) to determine whether a Pre-Petition Custody Order is appropriate
- Convene a case staffing to determine plan of action
- Complete Pre-Petition Custody Order, if appropriate

CPS AND THE LAW



INTRODUCTION

The purpose of any state or local CPS administration is to protect children from being abused and neglected, *as well as* to help families access services to acquire the skills and knowledge to prevent further abuse and neglect. As a CPS investigative social worker, your intervention into the lives of families being served by CFSA is guided by federal legislation, in addition to the District of Columbia's Code and its Municipal Regulations (DCMR). In particular, federal legislation sets all national CPS practice standards by defining uniform goals for CPS cases across the country. CFSA's practice standards, in addition to its policies and procedures, are in full compliance with both federal and District rules and regulations. As a CPS social worker, it is important that you understand the current laws pertaining to child abuse and neglect in the District. The Code and DCMR are internet-accessible at <http://government.westlaw.com/linkedslice/default.asp?SP=DCC-1000> and at www.dcregs.dc.gov respectively.

Finally, you are obliged to have a working knowledge of the District's Family Court system, and of course, CFSA's Policy Manual which is accessible on the Agency's website under "Information" on the main page at www.cfsa.dc.gov.

THE ESTABLISHMENT ACT

The *Child and Family Services Agency (CFSA) Establishment Act of April 2001* (DC Code § 4-1303.01a) confirms CFSA's authority as a separate cabinet-level agency responsible for the care of child welfare services in the District. As a result, the Agency through its director reports directly to the Mayor.

The *Establishment Act* specifically gives legal authority for CFSA to do what appropriately needs to be done in order to protect children's well-being and to keep them safe either in or out of their homes. This authority is granted through the following sections of the DC Code:

1. **§4-1303.01a (b)(3)** - CFSA has the responsibility to receive and to respond to reports of child abuse and neglect.
2. **§4-1303.01a (b)(3A)** - in response to reports of abuse and neglect, CFSA shall assess the strengths and needs of those children and families involved with the reported allegations.
3. **§4-1303.01a (b)(6)** – the Agency is responsible for safeguarding the rights and protecting the welfare of children when their parents, guardians, and/or custodians are unable to do so.
4. **§4-1303.01a (b)(4)** – when necessary for their safety and well-being, CFSA may remove children from their homes or other places.

In addition to the above authorities, **§ 4-1301.06** entrusts CFSA with certain obligations regarding the investigation of child abuse and neglect reports. The Agency must complete all investigations *within 30 days* of the first notice, with an additional 5 days to complete a final report. Documentation of each investigation shall

include at a minimum the following information:

- (1) The nature, extent, and cause of the abuse or neglect, if any;
- (2) If a mental injury is suspected, an assessment of the suspected mental injury by a physician, a psychologist, or a licensed clinical social worker;
- (3) If the suspected abuse or neglect is determined to be substantiated:
 - (A) The identity of the person responsible for the abuse or neglect;
 - (B) The name, age, sex, and condition of the abused or neglected child
and all other children in the home;
 - (C) The conditions in the home at the time of the alleged abuse or neglect;
 - (D) Whether there is any child in the home whose health, safety, or
welfare is at risk; and
 - (E) Whether any child who is at risk should be removed from the home or
can be protected by the provision of resources....

Special Note: CFSA policy requires more extensive information than is required by DC law to be included in your case documentation, as well as information entered into FACES.net.

TEN TYPES OF NEGLECT: *DC CODE § 16-2301(9)(A)* (i-x)

The DC Code contains 10 legal definitions of a neglected child that are important for every CPS social worker to know and understand. It is important to understand that “abuse” is a subset of “neglect” as an abused child is the first of the ten definitions. Unfortunately, the DC Code is not written as clear as it could be and a specific example of that is in the first definition of a neglected child which includes both an “abandoned or abuse” child. In addition, parents, guardians or custodians are not “charged with” or “responsible for” neglect, but rather, the child is found to be a “neglected child”.

You should familiarize yourself with each of the following legal definitions for the ten types of neglect. Be mindful of these legal definitions at the beginning, middle, and end of each of your investigations. The beginning because every investigation must begin with an investigation to determine if a child meets at least one of the definitions of neglect; the middle because during the investigation, all ten definitions must be considered, and the end because your finding(s) as to whether the child is a neglected child must be directly linked to one or more of the ten DC Code Citations. **REMEMBER:** *these cases are about the status of the child and not about*

placing blame on a parent, guardian or custodian. If there are questions that arise during an investigation as to whether the circumstances, as you see them, rise to the level of neglect, please consult your management team. *Should you need legal advice, please consult the Office of the General Counsel (OGC) for non-court involved cases and the Office of the Attorney General (OAG) for court involved cases.*

ONE - The term "neglected child" means a child:

DC Code §16-2301(9)(A) i

who has been **abandoned** or **abused** by his or her parent, guardian, or custodian, or whose parent, guardian, or custodian has failed to make reasonable efforts to prevent the infliction of abuse upon the child. The term "reasonable efforts" includes filing a petition for civil protection from intrafamily violence.

"Abandoned" is defined in DC Code §16-2316(d) (1) in four parts:

- I. The child is a foundling (i.e., a child found alone or abandoned and whose parent can not be located) and whose parent has made no effort to maintain a parental relationship with the child and reasonable efforts have been made to identify the child and to locate the parents for a period of four (4) weeks since the child disappeared.
- II. The child's parent gave a false identity at the time of the child's birth, and has then made no effort to maintain a parental relationship for at least four (4) weeks.
- III. The child's parent, guardian or custodian is known but has abandoned the child by making no reasonable efforts to maintain a parental relationship with the child for at least four (4) months.
- IV. The child is a boarder baby (i.e., the child was abandoned at the hospital upon birth).

"Abuse" is defined in DC Code §16-2301(23)(A) in three parts:

- i. the infliction of physical or mental injury upon a child
- ii. sexual abuse or exploitation of a child
- iii. negligent treatment or maltreatment of a child

"Unexplained injury" is defined in DC Code §16-2316(c) and states "where the petition alleges a neglected child by reason of abuse, evidence of illness or injury to a child who was in the custody of his or her parent, guardian, or custodian for which the parent, guardian or custodian can give no satisfactory explanation shall be sufficient to justify an inference of neglect." Therefore, if there is an unexplained injury the child may be found to be an abused child under DC Code §16-2301(9)(A)(i).

Note: when determining whether a child is a neglected child due to abuse, the CPS worker must use their clinical judgment. If necessary, any concerns or questions can be discussed with your CPS management team or one of the OAG attorneys.

***Special Note:** according to DC Code §16-2301(23)(B), abuse does not include discipline administered to a child*

by a parent, guardian or custodian provided that the discipline is reasonable in manner and moderate in degree and otherwise does not constitute cruelty.

When determining abuse based on a caregiver's claim that he or she was disciplining the child, clinical judgment must be carefully applied. In accordance with the above section, **discipline does not include** any of the following acts:

- (i) burning, biting, or cutting a child
- (ii) striking a child with a close fist
- (iii) inflicting injury to a child by shaking, kicking, or throwing the child
- (iv) non-accidental injury to a child under the age of 18 months
- (v) interfering with a child's breathing
- (vi) threatening a child with a dangerous weapon or using such a weapon on a child

Finally, the Code notes that the above listing is only illustrative of unacceptable acts of discipline and is not intended to be exclusive or exhaustive. In other words, clinical judgment shall be the determining factor when other types of acts are involved in the alleged discipline of a child.

TWO - The term "neglected child" means a child:

DC Code §16-2301(9)(A) ii

who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his or her physical, mental, or emotional health, and the deprivation is not due to the lack of financial means of his or her parent, guardian, or custodian.

This Code section encompasses many types of neglect. Some examples are a dirty house, educational neglect, improper supervision, unmet medical or mental health needs of a child, inappropriate living environment, and/or ongoing exposure to domestic violence. These are only a few examples of what falls under this section of the Code.

Note that in order to demonstrate neglect based on this definition, the neglect must be unrelated to financial means. Sources of income and public benefits must be assessed. Usually, if the parent is receiving some form of public benefits or could be receiving some form of public benefits, this requirement is not an issue. Also, if the neglect is unrelated to finances, this is not an issue. If the sole reason for the neglect is lack of money, the child may not fit this definition. That does not mean that the neglect would not fall under some other provision of the Code. If you have concerns regarding this, consult your management team.

THREE - The term "neglected child" means a child:

DC Code §16-2301(9)(A) iii

whose parent, guardian, or custodian is unable to discharge his or her responsibilities to and for the child because of incarceration, hospitalization, or other physical or mental incapacity.

This Code section clearly demonstrates that child neglect is a “no fault” process in that it does not look to the parent, guardian or custodian to “blame” for their behavior, but looks instead to the child – and how the child is affected. This section applies to a child when a parent, guardian or custodian is not able to care for the child due to being in jail, in the hospital or having a physical or mental incapacity. **Substance abuse and mental health of a parent will fit this definition only when that problem impacts the care of the child.** The fact that a parent abuses drugs or has a mental health issue does not alone equal neglect. Under this provision, it is essential to consider how the problem impacts the child, i.e. there is a nexus (a connection) between the parent, guardian or custodian’s substance abuse and/or mental health and the child. It is also important to consider whether the parent with the problem made a plan for the care of the child. For example, if a parent is incarcerated or goes into drug treatment and plans for another parent, grandparent or friend to care for the child, then there is likely no neglect. These situations must be considered on a case-by-case basis in conjunction with your supervisor. You should also consider the section of this guide that discusses Safety Planning.

FOUR - The term "neglected child" means a child:

DC Code §16-2301(9)(A) iv

whose parent, guardian, or custodian refuses or is unable to assume the responsibility for the child's care, control, or subsistence and the person or institution which is providing for the child states an intention to discontinue such care.

This Code section is a two-prong test. The first part requires a parent, guardian, or custodian to refuse or be unable to assume care for the child. The second part is that the person or institution who is caring for the child states that they (the person or institution) will no longer care for the child. This situation often arises when a parent leaves a child with someone else, does not return for some period of time, and the caretaker becomes unwilling to continue to care for the child. In some cases, the unwilling caretaker might be a hospital who has a child ready for discharge and no parent is available to take the child home.

FIVE - The term "neglected child" means a child:

DC Code §16-2301(9)(A) v

who is in imminent danger of being abused and another child living in the same household or under the care of the same parent, guardian, or custodian has been abused.

This Code section applies when one child in a home has been abused and there are other children in the home determined by the social worker to be at serious risk. *You must have one child who has been abused for this Code section to apply.* You must also keep in mind that just because one child was abused does NOT automatically mean that the other children in the home are in imminent danger. You must make an independent clinical assessment of every other child to determine risk. You should look at factors such as, age of the child, history of the family, severity of the abuse, special needs of the child, and whether the other children are similarly situated to the abused child.

Reminder: if you have any questions, you may always seek legal advice from the Office of the General Counsel (OGC) and/or the Office of the Attorney General (OAG-CPS).

SIX - The term "neglected child" means a child:

DC Code §16-2301(9)(A) vi

who has received negligent treatment or maltreatment from his or her parent, guardian, or custodian.

This section generally applies when **a child has not received doctor-recommended medical treatment.**

SEVEN - The term "neglected child" means a child:

DC Code §16-2301(9)(A) vii

who has resided in a hospital located in the District of Columbia for at least 10 calendar days after being born, despite a medical determination that the child is ready for discharge from the hospital, and the parent, guardian, or custodian of the child has not taken any action or made any effort to maintain a parental, guardianship, or custodial relationship or contact with the child.

This applies to “boarder baby” cases. Current case law permits the newborn to *not necessarily* be ready for discharge for ten (10) days, but 10 days must have passed since the child’s birth.

Reminder: if necessary, seek legal advice from the OGC and/or the OAG when encountering this scenario.

EIGHT - The term "neglected child" means a child:

DC Code §16-2301(9)(A) viii

who is born addicted or dependent on a controlled substance or has a significant presence of a controlled substance in his or her system at birth.

This section is used when a medical professional has determined that the child is born addicted or dependent on a controlled substance or has a significant presence of a controlled substance in his or her system at birth. Hospitals are required by law to call the Hotline when a child's system reveals the presence of a controlled substance. Seek legal guidance when necessary.

Special Note: DC Code limits the judge (but not necessarily CFSA) from making a finding of neglect if the finding is "based solely on a finding of the drugs in the child's system". In order to do so, the judge must find that the child has been negatively affected because of the drugs (*see DC Code §16-2317b*) or find that the child is a neglected child based on another DC Code section.

NINE - The term "neglected child" means a child:

DC Code §16-2301(9)(A) ix

in whose body there is a controlled substance as a direct and foreseeable consequence of the acts or omissions of the child's parent, guardian, or custodian.

This section is used when a child has a drug in her system that was not prescribed to the child, and their parent, guardian or custodian could or should have prevented the child from ingesting the drug.

TEN - The term "neglected child" means a child:

DC Code §16-2301(9)(A) x

who is regularly exposed to illegal drug-related activity in the home.

This Code section is used when a child is living in a home where illegal drug-related activity takes place (e.g., selling, purchasing, using, manufacturing, etc.) and the child is a witness to the activity or is otherwise exposed to the activity.

PAPERING A CASE

If you have made a clinical determination that a child's safety is at risk and removal from the home is required, **or** if you are seeking the Court's intervention (and power) to assist the Agency in alleviating an allegation of neglect without necessarily removing a child, there are several mandatory steps that you must take in order for the OAG to bring a case to the Court. These steps will lead to the start of a Family Matter – Neglect – Court

Case. This “papering” process, in effect, petitions the Court to enforce the legal rights of the Agency to protect a child in its care. You must inform the OAG of the specific facts to support an allegation of neglect (i.e., one or more of the ten Code sections listed above) before the OAG can file it with the Court. You must also state the general reason(s) CFSA believes the child is a neglected child. The OAG will determine which of the Code sections is applicable to the clinical and factual reasons you give that the child is a neglected child. As the CPS investigative social worker, it is your responsibility to meet with the AAG to discuss, review and sign the neglect petition.

Please note that additional procedures regarding management of removals are addressed in chapter 10 of this guide. Please refer to this section for additional aspects of removal.

Procedures

If you and your supervisor, in conjunction with one of the CPS program managers or program administrator, have concluded that a child must be removed for his or her safety, you must realize that the AAG has to be able to prove to the judge that there is **probable cause*** that the allegations in the petition are true. Without such a determination, the child (if removed) will have to be returned. (The case will still proceed in Court – but the child may remain in the home.)

***For purposes of this practice guide, probable cause is a legal term meaning that there are sufficient facts for the Court to conclude that the allegations in the petition are true. If the Agency is unable to prove probable cause during the hearing, the child will not be able to be, or remain, removed. The child will have to be returned home immediately. S/he cannot remain out of the caregiver's custody.**

Under certain circumstances, you may not be clear as to whether to remove the child or not and in those circumstances should consult your supervisory chain. In non-removal cases, you should feel free to contact any assistant attorney general (AAG) to make an appointment, or even just to “walk in” to discuss whether there is sufficient information to petition a case in court.

However, if you are on scene where a child may be in immediate danger, you should first consult your supervisor or management team prior to leaving the child(ren) in a potentially dangerous situation. This is critical because by leaving the child you may be inadvertently expressing that the child is safe; making a future removal more complicated to pursue in court.

If a child is removed, you must immediately generate a complaint form as a first step in the process of protecting the child's safety and well-being.

Complaint forms are accessible through the FACES referral screen using the "Court" drop down box. *Note: in the event that an on-going social worker initiates a complaint from an existing case, the complaint forms are also accessible through the FACES case screen. Please see the Complaint data flow chart in the appendix.*

In addition to all demographics, the completed complaint form shall justify the removal and include (at a minimum) the following information:

- Hotline report (excluding any identifying information on the reporter)
- FACES search
- Contact with the reporter (but not identified as the reporter)
- Contact with parents, caregivers, alleged perpetrators
- Contact with all children and/or siblings
- Description of injuries, if applicable
- Contact with all collaterals, if applicable
- Results of medical testing, if applicable and available
- Detective's information, if applicable
- Criminal history, if applicable
- Concluding paragraph summarizing the specific reasons for removal and any other information relevant to the child's safety and well-being

Once the form is completed, you should submit it via FACES to your management team for approval.

Note: prior to your management team's approval, the form will carry a "DRAFT" watermark. Only after your management team has approved the form in FACES will the watermark disappear.

Your management team will review the form, confirm that the date and time of removal is accurate, and check that the geographic location, i.e., the District Ward where the allegation is supposed to have occurred, is accurately identified as Ward 4, or Ward 5, etc.

Effective July 19, 2010, complaints will be submitted electronically to the Court and you will only need to print a copy for the hard file for the family.

Complaint forms received by the OAG are distributed to the AAG scheduled to paper cases for that week.

- *You should contact the papering AAG on the day the complaint form is delivered to court and request a scheduled interview.*
- *Once the interview is scheduled, you must ensure your availability for the appointed time. If that does not happen, you should appear at the AAG's office at **8am** the day of the initial hearing.*
- *During the papering interview, you might feel as if the AAG is questioning your clinical decisions. To the contrary, your clear and concise answers to their questions will help them present accurate information before the Court. **It is the AAG's responsibility to turn your clinical decisions into legal decisions.***
- *If the papering AAG notifies you of an intention not to paper the case, you must immediately notify your management team of the decision. If you have concerns about that decision you should immediately bring your supervisor into the discussion.*

What Legally Occurs after CFSA Takes Custody of a Child?

(A) A guardian ad litem (GAL) shall be appointed within 24 hours (excluding Sundays) of the child having been taken into custody.

The GAL is an attorney who **represents the best interests of the child**, not just the child's wishes in general. For example, if the child wants to go home, the GAL must believe that this natural desire to return home is also in the best interest of the child's safety and well-being. The GAL will not necessarily advocate for the child's return merely based on the child's natural desire.

(B) An initial hearing will take place within 72 hours (excluding Sundays) of the child being taken into custody.

An initial hearing is a court proceeding where the judge is asked to order the child into foster care. If the court disagrees, the child must be returned home, even though both the court case and the case with CFSA remain open.

(C) A petition must be filed by the AAG on behalf of CFSA (see "Papering a Case" above) at or prior to the shelter care hearing.

During the 72-hour period before appearing in court, CFSA may convene a family team meeting (FTM) to develop a safety plan approved by the Agency with the input of family members, relatives, and/or others concerned with the welfare of the child. At a minimum, the FTM participants should include the birth parents, relatives, caregivers, community representatives, service providers, and the guardian ad litem appointed to represent the child's best interest.

Special Note: you are responsible for **all** court-related activities prior to the transfer of the case to ongoing services as well as two specific matters that typically occur after case transfer. These include but are not limited to the following activities:

- participation in initial and further initial court proceedings
- participation in mediation
- participation in trial
- completion of complaint and mediation report
- completion of interim and disposition reports if they are required during your case responsibility, but typically these are the responsibility of ongoing

REMINDER: All documentation must be entered into *FACES* and hard copies submitted prior to the initial court hearing which is mandated to occur within 72 hours of removal. **Special Note:** neither hearings nor complaint filings occur on Sundays. Removals that take place on a Thursday or a Saturday will have their respective scheduled hearing or complaint filing on the following Monday. Please see the court schedule in the appendix because this depends on the time of the removal on a Thursday or Saturday.

Community Papering

When CFSA has been working with a family through an in-home case, there may come a time where the social worker thinks court intervention is needed to ensure that the family complies with the recommendations of the agency. These cases are no longer in CPS and the family is receiving services from an “in home” social worker. “Community papering” is the process that must be followed.

Community papering is appropriate when CFSA (or one of the contract agencies) has an open case with the family and there has not yet been a removal. If there has already been a removal, community papering is not appropriate and the process for removal papering (72 hour papering) should be followed.

Community papering occurs every Friday (except holidays) on the 5th floor at CFSA with the OAG/CPS attorneys. There is a clipboard at the OAG/CPS receptionist's desk detailing the availability for appointments. Social workers seeking to community paper a case should sign up for an appointment by either coming to the

5th floor or by contacting the OAG/CPS receptionist at 727-3839.

When meeting with an AAG, bring a complaint form as well as any supporting documentation (i.e. school, medical or mental health records) that show that the family has not been complying with the law or professional recommendations to show that this lack of compliance rises to the level of neglect.

Social workers should complete a complaint form and bring it with them to his/her appointment. The complaint form should not be filed with the court in advance of the appointment. Once an AAG indicates a decision to petition the case has been made, the social worker can then complete the complaint process. The complaint form should detail the reason(s) for agency involvement, the efforts made by the agency to address the neglect, and the reasons why those efforts have not succeeded in ameliorating the neglect. In short, why is the social worker recommending court involvement at this time?

During the social worker's appointment, the AAG will read the complaint and then will proceed to conduct a papering interview with the social worker. The purpose of the papering interview is to ascertain more information so as to determine whether or not a legal basis exists to paper the case. Additionally, the AAG may inquire, if it appears that there is a safety or risk issue, why a removal has not occurred. Removal decisions, however, are clinical decisions and the social worker should have already discussed that with his/her supervisor and/or program manager in advance of meeting with the AAG.

If the AAG determines that a legal basis exists, the AAG will prepare the petition and then request an initial hearing with the court. Initial hearings are to occur within 5 days of the filing of the petition, so the social worker and AAG should discuss availability of both the social worker and the parent(s). Once the AAG is notified of a date and time for the initial hearing, the AAG will notify the social worker who will then notify the parent(s).

If the AAG determines that a legal basis to paper the case does not exist, the AAG will complete the community papering no paper form, obtain his or her section chief's signature, and then provide the form to the social worker. If the AAG determines that a legal basis exists, but supporting documentation is needed prior to going forward, the AAG will delineate the type of information needed. The social worker should gather that information no longer than 5 days from the meeting and return to the same AAG. If longer time is needed, the social worker should sign-up again when the information is obtained.

Pre-Petition Custody Order

In the event that you are unable to locate a child who is involved in your investigation, and you've determined that the child is, or may be, in immediate danger from his or her surroundings, or you have established reasonable grounds to believe that the child is suffering from an illness or injury or is otherwise endangered such that removal from the child's surroundings is necessary, then you must complete both an [affidavit](#) and a [request](#)

for a pre-petition custody order.

The affidavit and request for custody order forms are templates that you can request from your management team.

Contact an OAG section chief for review and to determine whether the custody order can be filed. The section chief can also provide advice regarding completion of forms, if necessary.

The following information shall be included in the completed affidavit and request for custody order:

- respondent's (i.e., the child's) name
- respondent's date of birth
- respondent's alias, if any
- respondent's address
- respondent's description (gender, race, height, weight, scars or distinguishing marks, youth division number, child's case number, police department identification number)
- nature of the complaint, i.e., description of allegations and detailed grounds for removal
- your name and title
- your signature (in the presence of the AAG who will swear you to the information)

If the AAG determines that all facts meet the legal standard for obtaining a custody order, he or she will sign off on the custody order and direct you to take the documents to the Central Intake Center in Room JM-520 at 500 Indiana Avenue, NW. You should wait for the custody order to be issued there. Once you receive the official custody order, please make sure you document the information in FACES as well as file the hard copy in the record.

INITIAL HEARING

If a child has been removed from the home, or CFSA is requesting that a child be removed from the home, the parent has the right to a **probable cause hearing**. *Be prepared! You will testify at this hearing.* Do not be nervous; simply answer the questions that are asked of you truthfully. **You are allowed to testify what you have learned through “hearsay”**, i.e., what another person has told you. For example, if you receive information from a doctor, you may simply state what the doctor said to you. This is different than at the trial phase where the doctor would have to give direct testimony.

A probable cause hearing is held to determine whether there is credible reason to believe that the allegations in the petition are true. This is separate and apart from a shelter care hearing which is held to determine whether the child or children should remain in shelter care (i.e. CFSA custody). These two hearings are generally combined for expedience.

The AAG will prepare you for this hearing during the “papering” meeting and again before the hearing itself.

At the conclusion of the hearing, the judge shall make one of two decisions:

- (A) Order shelter care, setting forth in writing his or her reasons for why the child's shelter care is required.
- (B) Order the child to be released if shelter care is not required under such criteria.

If a child is ordered released, the judge may impose one or more of the following conditions:

- (A) Placement of the child in the custody of a parent, guardian, or custodian, or under supervision of a person or organization agreeing to supervise the child or youth.
- (B) Placement of restrictions on the child's travel, activities, or place of abode during the period of release.

You should be prepared to suggest services for the child and for the family to reduce the risk of further abuse or neglect. You should also prepare a proposed visitation schedule (with conditions, if necessary) before the hearing. It is important to include sibling visitation and how it will occur. If the child is to remain at home, be prepared to suggest conditions for the Court to order the parent, guardian or custodian to follow in order to ensure child safety. You should work expeditiously to get emergency licensing information to interested relatives.

When removal is necessary, the Agency will always require that a child is placed with a licensed foster parent. This includes placement with a relative. Consult your management team and CFSA Policy on how to request emergency licensing information but remember: the government will always object to a placement if the emergency license has not yet been granted.

Also, keep in mind that CFSA depends upon Title IV-E funding (a percentage of the money CFSA spends may be reimbursed by the Federal government if proper documentation is maintained) for the life a case. *This funding is contingent to the court's findings.* Your testimony to the court must support either one of the following two findings in order for Title IVE funding to be approved:

- (1) Reasonable efforts were made by the Agency to prevent removal of the child.
- (2) The risk of harm to the child was so serious that the failure of the Agency to make reasonable efforts was a proper choice under the circumstances.

Initial Hearings – Schedule

For initial hearings scheduled **Monday through Friday**, court begins at **11am**. *To ensure timely attendance, CFSA notifies parents to appear at 10am.* This allows sufficient opportunity for parents to go to the Center for Child Abuse and Neglect (CCAN), to participate in an eligibility interview, and to meet with their attorneys.

There are two magistrate judges assigned to hear initial hearings each week. In this manner, both CFSA's AAG divisions can be accommodated. The papering AAG will have the information for the appropriate division and can provide it to you when you meet to paper the case. You must notify the parent of date and time of hearing at the time of the child's removal.

For **Saturday and holidays**, there is only one AAG papering for both divisions. **Court is held at 10am in JM-15.** A schedule for these times is kept on the desk of the OAG receptionist with the name of the AAG papering for each division and for Saturdays.

CFSA CUSTODY OF THE CHILD

CFSA has the legal authority to place a child in any one of the following appropriate foster care options (DC Code §16-2313):

- (1) a family-based or therapeutic foster home
- (2) a group home, youth shelter, or other appropriate facility for non-delinquent children
- (3) a facility for specialized shelter care designated by the Placement Services Administration, including an appropriate facility operated by the District of Columbia

Special Considerations

Visitation

DC Code §16-2310(d) requires weekly (at a minimum) visitation by a child's parent, guardian or custodian when the child has been placed in shelter care, unless it appears to the judge that such visitation rights would create an imminent danger to or be detrimental to the well-being of the child. In which case, the judge shall either establish special conditions for visitation or order that visitation rights not be allowed.

Orders for Physical and/or Mental Examinations

Once the AAG has filed the neglect petition, a Court Order may require a child to be examined to aid in determining his or her physical or mental condition. **DC Code §16-2315** permits physical and mental examinations of a child. Orders might also be given for mental health examinations of a parent, guardian or custodian. You should discuss the need for such examinations with your management team as well as the AAG, either before, during, or shortly after the papering session.

General Legal Considerations

As is the case with each procedural step involving a child's entry into care, all relevant facts and information must be entered accurately into FACES. The importance of accurate documentation in FACES cannot be underestimated! Not only does it protect the rights of the child, accurate documentation protects the integrity of data that the Agency must maintain in the event of local and/or federal reviews and audits. ***All documentation must be entered into FACES*** and hard copies submitted prior to the initial court hearing which is mandated to occur ***within 72 hours of removal.***

HOLDS

Hospital Hold – This term is only used internally by CFSA when a child is currently hospitalized and you have reason to believe it is not in the child's best interest to be released to the child's parent (or guardian or custodian). You may then request that the hospital “hold” the child until a court order grants custody to CFSA. **You still need to file a complaint and you should advise the hospital that the process to file a complaint has begun or will soon begin accordingly.** Under these circumstances, the hospital may agree to “hold” the child but this agreement between the hospital and CFSA has no real legal effect. Please see appendix ... for an example of such paperwork.

It should be noted that the police are able to complete holds as well that do not require a complaint to be filed. At times this strategy may be beneficial in ensuring the safety of a child during a joint investigation without having to immediately bring a case into court. You must remain in close communication with the detective; however, as you need to be aware when the hold is lifted so that you can take any needed safety measures on behalf of the child; potentially including removal.

Administrative Hold – Although not a legal term, it is sometimes used interchangeably with “hospital hold”. In your FACES documentation, a child who is removed is under an “administrative hold” until the matter is taken into court and the child is either returned to the caregiver or a shelter care order is instituted.

72-hour hold – This term is used to describe the legal time period within which CFSA may remove a child from the parent, guardian or caretaker before being entitled to a court hearing and filing a petition alleging neglect.

5-day hold – When a complaint has been filed after the removal of a child, OAG may request that the court permit up to 5 additional days for CFSA to continue the investigation before returning to court for the initial hearing, at which time a petition must be filed, or the child can no longer remain in care. If the Court finds that there is “good cause”, OAG will be granted the “5-day hold” but again, by the end of those 5 days OAG must file a petition for neglect or return the child. The parent or legal caregiver still has a right to request a shelter care hearing to determine whether the child should remain in CFSA custody during this time.

90-day hold – This term is actually out of date. It was formerly used to describe the 90-day period of time that CFSA permitted parents, guardians or custodians to voluntarily place their child into CFSA care. CFSA no longer utilizes this process.

Unaccompanied Refugee Minors

This is a legal term used to describe children who have been brought to the United States from another country and who come into the care of CFSA based on federal law. In general, CFSA is not involved and such cases do

not start with an allegation or a report to the 24-hour Hotline system. The term is used when the US Department of State identifies refugee children overseas who are eligible for resettlement in the U.S. but do not have a parent or a relative available, and the US is committed to providing for their long term care. Upon arrival in the US, these refugee children are placed into the Unaccompanied Refugee Minors (URM) program to receive refugee foster care services and benefits. The URM Program helps these children and/or youth develop appropriate skills to enter adulthood and to achieve social self-sufficiency.

Procedures

- Lutheran Social Services (LSS) will usually bring these cases to CFSA's attention based on LSS' ongoing contract with the District for this purpose.
- The LSS social worker prepares a complaint form and signs up for community papering. Remember that community papering requires only a conversation with the attorney to determine if a neglect petition is appropriate. In order to proceed to papering on this type of case, the child has to be classified as a URM by the federal Department of Health and Human Services (HHS). The LSS social worker should have this documentation. On occasion, a child might be an asylee who was reclassified as URM by HHS.
- Once the child is brought to CFSA's attention, the AAG prepares a petition alleging a Subsection IV allegation for an unwilling caretaker (*see attached petition example*).
- The petition with an attached complaint is filed in the DC Superior Clerk's office (as in a community case) and a date is subsequently set for an initial hearing; the Clerk's office should be notified that the case is an unaccompanied refugee minor case.
- The AAG prepares findings of fact and conclusions of law.
- The AAG also prepares a disposition order (instead of an initial hearing order).

If you have a case involving a minor alleged to be an "unaccompanied minor", contact your program administrator and the OGC.

DIPLOMATIC IMMUNITY

The District of Columbia is uniquely situated as both a residential area and the nation's capital city where foreign dignitaries hold resident in the embassy or consulate representing their native countries. As a result, there may be times when a Hotline report involves someone (the parent, guardian or custodian or often the child) who has diplomatic immunity. *Children who have diplomatic immunity or children of parents, guardians or custodians who have diplomatic immunity are not subject to United States or local laws.* The moment you have reason to suspect that the parent, guardian or custodian is a diplomat, or that the child has **diplomatic immunity**, your investigation must cease until further instructions are given by the OGC.

In collaboration with the US Department of State, the OGC will determine whether in fact a diplomat is the subject of a neglect investigation. *Special Note: not all non-citizens claiming to have diplomatic immunity do in fact have diplomatic immunity.* Further, if it comes to your attention that the life of a child is at risk, you are

obligated to act appropriately to immediately protect the child. Contact your management team as soon as possible, and/or contact the OGC for further instructions.

THE CPS INVESTIGATION



THE CPS INVESTIGATION

All CPS reports are first screened by Hotline workers who utilize clinical judgment and a standardized “decision tree” in FACES to determine whether or not an investigation is warranted. Based on this determination, the Hotline worker will assign a **response time** that tells the CPS investigative worker whether to make an initial face-to-face contact with the child victim **within 2 hours (“immediate response time”)** or **within 24 hours (“regular response time”)**. The Hotline worker will then submit the referral to the assigned Hotline supervisor for approval. If approved, the Hotline supervisor will forward the referral to the CPS supervisor who shall ultimately assign the referral to an investigative social worker.

INITIAL FAMILY BACKGROUND RESEARCH

Even when an immediate response time is assigned, the investigative social worker and/or the management team must still follow certain pre-investigation steps whenever possible prior to initial contact, or as soon as possible after the initial contact with the child victim. This includes a review of all available information or records on the child and/or family to help you identify if any of the following situations may need to be addressed:

- Possible safety threats
- History of, or a pattern of, abuse or neglect
- Child and family support systems and protective capacity
- Specialized needs of the children or caregivers
- Any possible worker safety issues
- Additional demographic information on a family

There are a number of things you will want to look for and think about the minute you receive a new referral. You must first thoroughly review the referral snapshot, recognizing that it is not typically or necessarily reflective of all family members or prior involvement with the Agency. Due to this reason, you will want always to conduct thorough searches for each referral that you receive. Several resources are available.

- **FACES.Net Search**
- **The Automated Client Eligibility Determination System (ACEDS)**
- **The Student Transmittal and Attendance Record System (STARS)**

FACES Search for Prior CFSA History

Thorough review of prior referrals and case history can be very useful in assessing chronic problems as well as strengths within the family. It can also reveal risk elements and prepare you for the home visit, in addition to assisting you with assessing child safety. You should consider the family's prior involvement with CFSA throughout your assessment of the family.

The **IMPORTANCE** of Reviewing **PRIOR HISTORY**

Why know history?

- It is critical to assess the new allegations in the context of all previous reports/allegations.
- Families may not openly reveal critical elements of their situation that would be helpful in your assessments, including the following information:
 - (a) Other children in the home or other children who may reside outside of the home
 - (b) Persons who are not allowed contact with the family through a protection order or visitation order

Knowledge of prior history can reveal important facts:

- Whether the current alleged child victim is the same as in prior reports
- The number of prior substantiated, inconclusive or unfounded reports
- Severity and type of current allegations compared to those in prior reports
- Results of previous safety interventions and services
- Written and verbal findings of staff who previously worked with the family
- Possible locations or living situations for families

Consider the following:

- Child's present condition, family functioning and household conditions as compared to prior reports.
- What does the pattern, and/or frequency of past reports tell us?
- The source of prior reports, i.e. Are there multiple reports with similar allegations called in by the same or different reporters?

ACEDS - Automated Client Eligibility Determination System

Many families who come to the attention of the District's child welfare system are recipients of public assistance from the District's Income Maintenance Administration (IMA). Such assistance may come in the form of food stamps, medical assistance benefits, and/or Temporary Assistance for Needy Families (TANF). Information on all recipients is entered into the ACEDS database and accessible to CPS investigative social workers for background information and family history. *Please see your CPS management team for additional information on reading an ACEDS report.*

- At the very beginning of your investigation activities, it is especially useful to search ACEDS for information regarding additional siblings and/or other household members.
- Keep in mind that the ACEDS database is shut down by 8pm on weekdays and has sporadic accessibility during the weekend.
- The ACEDS system is searched by NAME ONLY, not by address. If you have only an address and not a family name, ACEDS will not provide information on the family.
- *NOTE:* families receiving assistance from IMA often fail to update their demographic information in a timely fashion with the IMA worker. As a result, such information in the ACEDS system may not always be current.

STARS – Student Transmittal and Attendance Record System

The STARS database tracks attendance records for students currently enrolled in DC Public Schools. At times, the database will also include some historical attendance records. Transcripts and class schedules are typically available for high school students. For grades K-8, however, progress reports must be obtained directly from the school of attendance. Unlike ACEDS, the STARS database does have the capability for “reverse searches”, i.e., the CPS investigative social worker can search for a family or child using only an address. As a result, STARS is a useful and complementary tool for locating and/or identifying a family when no other demographic information is available.

- The STARS database is generally accessible 24-hours a day.
- STARS information separates partial absences (e.g., from class) versus full absences (i.e., an entire day or more) for both middle and high school student attendance reports. Please note that absences recorded in the database do not necessarily reflect whether the absence was excused or not.
- *Keep in mind that attendance information may not always be accurate.* When utilizing this information to substantiate a neglect allegation, you should definitely have a conversation with the school official for confirmation. Be sure to carefully document this information in your investigation notes.
- Pulling the student information card may also have helpful information, such as the listed address for the family, caregivers' names, and emergency contacts.

PRE-INVESTIGATION CONSULTATIONS

Contacting the Reporting Source

You are required to contact the source of the report immediately to obtain further clarification and information about the allegations. [This is one of the core contacts](#). This initial contact may also lead to other persons who can provide information as to whether safety factors are present that may place the child in immediate danger or impending danger of harm. If the source is not immediately available, continue to contact the source until you are able to make contact.

Be prepared to explain to all reporting sources that the investigation is confidential and that you cannot share information without the proper releases. This can be difficult for individuals who are genuinely concerned about children so acknowledge this when you speak with the reporting source.

Remember that individuals who report may not have the first hand information about which they are reporting. You must then also reach out to the original reporting source to clarify the allegations and any other investigation concerns. For example, a reporting source may share information that they have received second hand from another family member, professional, or concerned citizen. Without revealing the reporting source, you should make efforts to confer with the person(s) who have direct information about the allegations.

Contacting the On-going Social Worker

When an investigation is received on an open case, the Hotline worker will notify both the on-going social worker and the management team. With this in mind, you should communicate with the on-going social worker prior to initiating the investigation. He or she will be able to provide you with key information about a family's functioning that will support your investigation and assessment activities. Whenever possible, you should jointly assess the allegations with the on-going social worker, even though you will still be taking the lead due to the specialty of your investigation skill set. If you are not able to quickly make contact with the ongoing team, this must not delay the initiation of your investigation.

Contacting the Metropolitan Police Department (MPD) (if applicable)

All reports involving allegations of child physical abuse and sexual abuse are forwarded to the MPD Youth Investigations Division (YID). From that point onward, an assessment is made by the MPD and the United States Attorneys Office as to whether the report meets the criteria for a criminal investigation.

If your investigation requires an immediate response, or what MPD might classify as a “hot case” (serious physical or sexual abuse), contact must be made with YID which will determine whether the investigation should be assigned immediately to them. Contact should be made at the main number (202/576-6768) with the detective or sergeant on duty who is assigning cases that day.

If your investigation is not assigned immediately at YID, but is determined to warrant a criminal investigation, it will be assigned according to a timeframe determined at YID. When assignments are made, YID notifies the CPS Special Abuse Supervisor; generally a few times a week. The supervisor in turn distributes this information via e-mail to the assigned investigator and supervisor.

If a report does not meet the criteria for a criminal investigation it will be **turned over to (TOT) CFSA**. Information regarding TOT investigations is sent to the CPS Special Abuse Supervisor, generally on a weekly basis. Again, the supervisor distributes this information via e-mail to the assigned investigator and supervisor.
***Note:** the acronym TOT is frequently used by MPD to identify the investigations that are turned over to CFSA. We include it here so you will recognize it in the future. It is pronounced “tee oh tee” and the past tense, TOT’d is pronounced “tee oh teed”.*

If you have not received communication from MPD regarding your investigation within 7 business days, please consult with your supervisor prior to contacting YID directly (via telephone or e-mail) to request information on the assigned detective or to determine whether the referral has been TOT’d to CFSA.

It should be noted that reports involving physical abuse or sexual abuse that resulted in an arrest being made by a District officer (as opposed to an investigator or detective from YID) are not assigned at YID, as the matter is considered to be closed with the arrest.

In the event that you are involved in a child fatality investigation you will still likely have contact with YID but the lead in these investigations is the MPD Special Victims Unit (SVU). Please refer to the child fatality section of this guide for additional detail.

General Guidelines

Under the “Establishment Act” of 2005, the Agency is mandated to conduct a thorough investigation into reports of suspected abuse or neglect to protect the health and safety of the children involved. The CPS interview is a fundamental component of this mandate. Ideally, the interviews with children will take place at a neutral setting, for example, the child's school. Interviews with caregivers are likely to occur at home but may occur in other environments (schools, hospitals, etc.). *Either way, you must make a home visit.*

Remember also that the information you get from one interview will likely be used to gather information from the next. To maintain the integrity of all gathered information, each person should be interviewed separately, typically starting with the alleged victim and other children. At times you will want to gain information from collateral sources of information (emergency physicians, teachers who witnessed alleged abuse, etc.) that have direct information on the facts of the assessment that will be needed when conducting the family interviews. The following interviews will be discussed in this section:

- Alleged victim and other children
- Non-offending caregivers
- Alleged perpetrator
- Other household members
- Collaterals

GUIDELINES FOR INTERVIEWING CHILDREN



According to DC Code §4-1301.04(c)(3)(A), CFSA, in order to protect the health and safety of children is to interview children without the presence of their caregiver(s). Specifically, “the initial phase of the investigation shall include seeing a child and all other children in the household outside of the presence of the caregiver or caregivers.”

REMINDER: You are required to interview and assess **ALL** children in the home. Each child should be afforded the opportunity to share individual accounts and to give individual explanations of the allegations on the referral. If a child is too young to be interviewed, he or she must be observed **awake**, and be assessed in reference to the caregiver or parent. (*See the Required Tasks for Interviewing Children below.*) You must ensure that all of the children involved with the family have been accounted for, including children living outside of the home, in other residences, and/or states. You must note the **time, date, and place** of each interview, and *you must enter this information in FACES.*

REQUIRED TASKS FOR INTERVIEWING CHILDREN

Required Task	Assess – Describe – Document
Assess the physical appearance of the child.	<ul style="list-style-type: none"> • Observe the child. • Take a photograph of the child (when applicable or appropriate). • Determine if the child’s clothing is appropriate for size and weather conditions. • Determine if the child is appropriately groomed (cleanliness, hair, odor, and so forth).
Assess whether the child has any physical injuries.	<ul style="list-style-type: none"> • Determine if the child needs immediate medical care. • Determine if the child has physical injuries. • Photograph any injuries. • Describe the size, shape, type and location of injury. • Describe whether the injuries appear acute, healing, or healed. <p>Note: for further details on injuries, see section below on <i>Guidelines for Observing Child Injuries (Normally Clothed Areas).</i></p>

Assess the child's affect, body language, behavior, and special needs	<p>Describe the following affects:</p> <ul style="list-style-type: none"> • Child's mood during the interview; note whether the mood changes related to subject matter. • Child's ability and/or desire to engage in conversation. • Any obvious challenging behavioral issues. • Any behavior or attitude that appears developmentally out of the norm. • Any known or suspected special needs.
Discuss the interview ground rules directly with the child	<p>The following information must be documented to attest to the child's legitimate participation in the interviewing process:</p> <ul style="list-style-type: none"> • Is the child aware of the difference between the truth and lying, and does the child agree to tell the truth? • Can the child state when s/he does or does not understand a question, and does the child agree to ask questions when s/he does not understand? • Does the child agree not to guess if they don't know an answer? • Has the child agreed to correct you if you say things that are incorrect?
Family and household composition	<ul style="list-style-type: none"> • Describe the members of the child's household and their relationship to the child. • Note whether there is more than one household involved. • Describe other significant persons in the child's life (extended family, godparents, other meaningful caregivers, etc.) • Specifically discuss the child's biological parents and grandparents or other meaningful caregivers, <i>even if they are currently absent from the child's life.</i>
Family relationships	<ul style="list-style-type: none"> • Describe the child's perception of each member of the household. • Assess specifically whether the primary caregiver has a significant other (who may or may not live in the home). • Assess for any domestic violence in the family (<i>see section on Domestic Violence, p. X of this Practice Guide</i>)
Family rules and responsibilities	<p>Discuss the following topics:</p> <ul style="list-style-type: none"> • Any rules that exist in the household. (Do not presume that there are rules.) • Responsibilities of different household members for chores, cooking, supervision, etc.
Family discipline practices	<p>Discuss and document responses to the following questions:</p> <ul style="list-style-type: none"> • How is rule-breaking handled in the family? • What happens if or when the children "get into trouble"? • Who is the primary disciplinarian in the family?

	<ul style="list-style-type: none"> • Is physical discipline used? Discuss type of object used, where the child is hit, how many times the child is hit, and how frequently it occurs in the family. • Are there any differences in discipline used with siblings or other children in the household?
Basic needs	<p>Discuss and document the following topics:</p> <ul style="list-style-type: none"> • Housing (sleeping arrangements, utilities, etc.) • Access to food (preparation of meals, any concerns for children going hungry, etc.) • Access to clean and sufficient clothing • Routine and necessary medical care
Health	<p>Discuss and document responses to the following questions:</p> <ul style="list-style-type: none"> • Does the child go to the doctor and/or take medication(s)? • Did you observe any health concerns during your assessment? • What is the primary physician's name and phone number? • When was the child's last doctor's visit?
Education	<p>Discuss and document the following information:</p> <ul style="list-style-type: none"> • Name and location of school • Attendance at school • Educational progress • The child's feelings about school
Supervision in the family	<ul style="list-style-type: none"> • Discuss responsibilities for supervision in the family.
Knowledge of drugs and/or illegal activity	<ul style="list-style-type: none"> • Discuss any knowledge of drugs and/or illegal activity.
Sexual abuse (precautionary)	<p>Discuss and document the following precautionary topics on sexuality:</p> <ul style="list-style-type: none"> • Child's knowledge of private parts. • Any experience with or anyone's attempt at inappropriately touching these parts. • What the child would do if something happened to their private parts. • If the child is uneducated with regard to their private parts and personal boundaries, give age-appropriate information and reinforce the importance of the child's ability to say "no" to bad touch.
General safety	<ul style="list-style-type: none"> • Discuss safety in general with the child and what it means to be safe, including any safety factors that the child may share.

Any additional information regarding the allegations not discussed above	<ul style="list-style-type: none"> • What, when, where, how? • Who was present? • Explanations of the incident and each allegation • How does the caregiver or maltreater feel about and react to the incident and/or allegations?
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Special Guidelines for Observing Child Injuries (Normally Clothed Areas)

When allegations include an injury (or injuries) on those parts of the body that are normally covered by clothing, you must consider how best to visually observe the injuries. Depending upon the allegations (or any additional information you've received during the course of your investigation), you may wish to consult with the CPS management team to determine what action is necessary for you to reach a conclusion regarding the child's immediate safety. When visual inspection is deemed appropriate, it is generally considered good practice to seek the parents' or caregivers' consent. You should use discretion, however, when deciding whether to examine the child in the presence of the caregiver.

Under certain circumstances, it may not be in the child's best interest to request consent or to inspect a child in the caregiver's presence. The following examples are not exhaustive but, in general, these are situations where it is likely **not appropriate** to seek the caregiver's consent or to examine the child in the caregiver's presence:

- At the onset of a joint investigation with the MPD Youth Investigations Division (YID).
- When there are concerns that a caregiver may impact the outcome of the investigation by coaching other children or collaterals.
- When the child's safety is at risk, or other children's safety is at risk.
- When a caregiver is a possible flight risk.
- When the location of all children has not been ascertained.
- When the caregiver is a threat to the well-being of the social worker.

The following examples are situations where it is likely to be **appropriate** to seek consent and to examine the child in the presence of the caregiver:

- To rule out physical abuse by documenting a lack of marks or injuries.
- When observing accidental injuries.
- If the caregiver present is the non-offending caregiver.
- Minor physical abuse.
- During a joint investigation in consultation with the YID detective.

Minimizing Impact on the Child During Visual Observations

To minimize the potential for negative impact on the child, you should consider the following factors:

- *Always conduct the visual observation in a place that supports the child's privacy and dignity.* If possible, use a medical professional's office space, e.g., a school nurse's office.
- *Always ensure that more than one person is present, preferably a caregiver and/or a professional other than yourself.*
- *If the child is age 4 or over, one of the persons present must be of the same gender.*
- Carefully explain to the child, using simple language, exactly what is happening and why.
- Reinforce the nature of the inspection as being conducted for the child's safety.
- Clarify with the child his or her right to personal boundaries, if age appropriate.
- Whenever possible, present the child with an option for a professional (e.g., social worker, school nurse, or pediatrician) to perform the visual inspection. Be sure that the child expresses comfort with the decision.
- If the child is not comfortable with the procedure, be sure to make every effort to allay any fears. Do not force the inspection!
- If the caregiver is present, and the child is unable to undress him/herself, ask the caregiver to undress the child.
- If the caregiver is not present, someone familiar to the child should assist.

You must photograph and document any observed injuries, including size, location on the body, shape and configuration.

If the injuries are severe, or potentially serious, or if medical attention is needed, the child should be seen by a physician immediately. The results of the examination should be thoroughly documented.

GUIDELINES FOR INTERVIEWING NON-OFFENDING CAREGIVERS

As with all interviews, you are responsible for conducting a comprehensive assessment of the immediate safety and risk of future harm for each child in the family, including but not limited to the direct allegations in the Hotline report.

Although this section specifies tasks for interviewing the non-offending parents or caregivers residing in the home, the basic tasks are the same for interviewing the alleged maltreater. You should follow the required tasks for both parties, particularly as the maltreaters are frequently the primary caregiver. If the maltreater is not a primary caregiver (such as an absent or infrequent parent), consideration may be given to what aspects of the caregiver interview are not applicable.

REQUIRED TASKS FOR INTERVIEWING CAREGIVERS RESIDING IN THE HOME

Required Task	Assess – Describe – Document
Face-to-face interview with parents and/or caregivers	<ul style="list-style-type: none">• Gather basic demographic information for all parties.• Obtain proper releases of information to be able to speak with collateral sources of information.
Assess the physical appearance of the caregiver.	<ul style="list-style-type: none">• Observe the caregiver.• Determine if the caregiver is appropriately groomed in terms of their cleanliness (hair, odor, and so forth).
Assess the caregiver's affect, body language, behavior, and special needs.	<p>Describe the following affects:</p> <ul style="list-style-type: none">• Mood during the interview; note whether the mood changes related to subject matter.• Ability and/or desire to engage in conversation.• Any known or suspected special needs.• Assess for immediate mental health needs
Family and household composition	<ul style="list-style-type: none">• Describe the members of the caregiver's household and relationship to the child or youth.• Describe other significant persons in the caregiver's life (extended family, paramours, etc.).

Family relationships	<ul style="list-style-type: none"> • Describe the caregiver's perception of the children. • Specifically assess whether the primary caregiver has a significant other (who may or may not live in the home). • Assess for any intimate partner violence in the family. • Discuss responsibilities that the caregiver may have for other adults (ailing parent or relative, etc.).
Family rules and responsibilities	<p>Discuss the following topics:</p> <ul style="list-style-type: none"> • Rules that may exist in the household. (Do not presume that there are rules.) • Responsibilities in the home for chores, cooking, supervision, etc.
Family discipline practices	<p>Discuss the following practices:</p> <ul style="list-style-type: none"> • How is rule-breaking handled in the family? • What happens when the children "get into trouble"? • Who is the disciplinarian in the family? • If physical discipline is utilized, what types of objects are used, where is the child hit, how many times is the child hit, and how frequently does the physical discipline occur? • Any differences in discipline used with siblings or other children in the household? • Give the caregiver(s) information on DC laws for corporal discipline.
Basic needs discussion	<ul style="list-style-type: none"> • Shelter • Food • Clothing • Employment • Finances
Health discussion	<ul style="list-style-type: none"> • Health insurance • Health provider • Last physical, updated immunizations, preventive screenings • Specialized needs • General hygiene
Educational discussion (if applicable)	<ul style="list-style-type: none"> • School and/or daycare enrollment • Caregiver involvement • Attendance • Educational progress • Specialized needs
Supervision in the family	<ul style="list-style-type: none"> • Discuss who handles supervision if the caregiver needs to be away or is at work.

Caregiver stress, support network, health	<p>Discuss the following topics:</p> <ul style="list-style-type: none"> • How the caregiver handles stress. • Any support network that the caregiver has in place. • Health issues that the caregiver may be facing. • Substance abuse. • Mental health issues.
<p>Substance abuse</p> <p>Mental health</p>	<p>Discuss the following topics:</p> <ul style="list-style-type: none"> • Caregiver history or current use of substances (illegal, legal, prescription). • History of or current issues with mental illness. • How either of these impacts his/her ability to care for, supervise, and/or protect the children. • Results of substance abuse/mental health assessment.
Legal issues	<ul style="list-style-type: none"> • Discuss any history or current involvement with the legal system.
Any additional information regarding the allegations not discussed above	<p>Non-offending caregiver's account [or alleged maltreater's account] of each allegation:</p> <ul style="list-style-type: none"> • What, when, where, how • Who was present • Explanations of the incident and each allegation • How does the caregiver or maltreater feel about and react to the incident and/or allegations?



THE HOME VISIT

Even if you do not interview in the home, you must still make a home visit and conduct a thorough assessment of the immediate living environment. This assessment will help you to determine whether there are any unsafe conditions that place the child in immediate or imminent danger.

ASSESSING THE HOME

Required Task	Assess – Describe – Document
<p>Visit and assess the home environment for the presence of safety factors. Document whether any of those factors pose immediate danger or imminent danger for the children.</p> <p>All family living areas must be examined. Living area means any area of a home or residence that is utilized by a family to include, basement, garage, attic, etc.</p> <p>Determine sleeping arrangements for all household members. Ensure that all infants have their own cribs (<i>see dangers of co-sleeping below</i>).</p>	<p>Do any of these potentially unsafe conditions exist in the home?</p> <ul style="list-style-type: none"> • No heat/hot water • Unsafe space heater or other heating methods • No gas • No electricity • Unsafe lighting (e.g., using candles) • No window guards • Non-working smoke alarm • Inadequate plumbing • Inadequate food supply • Inadequate or lack of sleeping arrangements (i.e., no bed or crib) • Unsanitary conditions and/or presence of vermin • Exposed wires • Broken taps, or taps running scalding water • Leaking gas • Broken windows and/or door locks • Exposed radiator and/or exposed pipes • No phone or disconnected phone • Toxic chemicals and/or harmful medications in easy reach of the child

GUIDELINES FOR INTERVIEWING OTHER HOUSEHOLD MEMBERS

You must interview ALL household members not just the parents or primary caregivers residing in the home. Establish and document all relationships in the home.

Required Task	Assess – Describe – Document
Relationship of household members	<ul style="list-style-type: none">• Determine the nature of the relationships between the household members (length of time known, length of time sharing the residence, etc.).
Knowledge of the household members regarding the allegations	<ul style="list-style-type: none">• Discussion should be held with the household members regarding any knowledge of the allegations.
Determine whether the household members have other knowledge regarding the safety and well-being of the children in the home.	<ul style="list-style-type: none">• Discussion should be held with the household members regarding the general safety and well being of the children in the home.• Specifically discuss supervision and discipline methods within the household.• Educate all household members on DC regulations regarding child abuse and neglect.
Assess the state of the household as it relates to all household members.	<ul style="list-style-type: none">• Determine whether there is appropriate living space for all household members (e.g., are family members sleeping on the floor, sharing beds, etc.).• Determine whether there is sufficient food and/or clothing for all household members.• Determine whether all household members have safe sleeping arrangements (e.g., safe cribs, etc.).

GUIDELINES FOR INTERVIEWING COLLATERAL CONTACTS

Collateral contacts are sources of information that are knowledgeable about the client's situation and serve to support or corroborate information. Collateral contacts include mandated reporters such as teachers and medical personnel, as well as other people in the community who may be relevant to the investigation. *Remember to familiarize yourself with Agency standards on confidentiality when conducting collateral interviews.*

Collateral contacts often provide a good deal of information that is helpful in determining the disposition (see p. 143 for information on the disposition decision). These interviews help you obtain additional information about the children and family that will help determine whether or not the children are in immediate danger or if there is risk for future abuse/maltreatment.

Key information to gather from collateral contacts includes:

- How long each collateral has known the child and/or family
- Collateral's assessment of the child's condition
- Collateral's assessment of family functioning, including their knowledge of any safety factors or risk elements that may be operating in the family
- Collateral's knowledge of the incident/allegations, and any other signs of abuse or maltreatment

All interviews with collateral contacts must be documented.

All CPS investigations require a minimum standard for obtaining information from collateral sources prior to the investigation's closure:

- You **must** make at least one **attempt** to obtain detailed information from medical providers, daycare providers, and educational providers. If this information is not pertinent to the disposition, the investigation may be closed without it *after discussion with your management team.*
- At a **minimum**, you **must obtain** the most recent available information on the child's immunizations and school attendance records if school age, both of which help to establish at least a minimal level of medical and educational care.
- You are required to attempt to obtain collateral information **within one week** of gaining knowledge of the identity of the collateral sources of information. *You must not wait until the end of the investigation to request information from collateral sources.*

REQUIRED TASKS FOR INTERVIEWING MEDICAL PROFESSIONALS

Required Task	Assess – Describe – Document
Immunizations	<ul style="list-style-type: none"> Request immunization records from a credible source (e.g., school records, medical provider, CFSA's Office of Clinical Practice, DC Department of Health, etc.). Review the immunization records to determine if the child is current, due, or overdue for immunizations. If the record indicates that the child is overdue for immunizations by one month or more, the worker should confirm any discrepancies with the medical provider and/or another credible source of information. <i>Note: the Department of Health does not update the system on a monthly basis.</i> If the caregiver has indicated that they have chosen to withhold immunizations, you should confirm that the appropriate paperwork has been submitted to the school, e.g., the caregiver has opted out for philosophical or religious reasons. <i>Note: documentation of this sort must be annually updated.</i> <p>Special Note: it is not against the law to withhold immunizations from a child, nor is it automatically considered medical neglect.</p>
Regular and/or preventive medical care	<ul style="list-style-type: none"> Request information from the medical provider (records or verbal confirmation). Request information regarding the caregiver's compliance with appointments, recommendations, and follow-up appointments.
Medical conditions or prescribed medication	<ul style="list-style-type: none"> Request information from the caregiver regarding any outstanding medical issues and/or any medications that have been prescribed for the child. Observe any prescription bottles and document the date that the medication was dispensed. Obtain information regarding appointments with specialists or any referrals to specialists. Confirm that the caregiver has been compliant with referrals and follows up in regards to any of the child's specialized needs.
Concerns of abuse or neglect	<ul style="list-style-type: none"> Determine whether the medical provider has any concerns of abuse or neglect

REQUIRED TASKS FOR INTERVIEWING

EDUCATIONAL PERSONNEL

Required Task	Assess – Describe – Document
Child's attendance records	<p>Request records from the school. Determine and document the following information:</p> <ul style="list-style-type: none"> • More than 10 unexcused absences in any given school year. • School policy on absences versus tardiness. • Whether absences are due to the child's truancy (despite caregiver's efforts) or educational neglect. • Notification to caregiver by the school with regard to the child's absences. • Whether the school has discussed the attendance issue with the caregiver. • School compliance with the appropriate steps outlined in CFSA's Memorandum of Understanding (MOU) with DC Public Schools (regarding truancy and educational neglect). • Filing of a DC Superior Court Truancy Referral Form to initiate court action. • Caregiver compliance with school recommendations.
Academic performance	<ul style="list-style-type: none"> • Obtain report cards or verbal reports from teachers or school staff regarding the child's academic performance. • Determine if poor academic performance is related to tardiness or excessive absences.
Special educational needs	<p>Determine and document the following information:</p> <ul style="list-style-type: none"> • Existence of a current individual education plan (IEP). • Participation of caregiver in development of IEP (if relevant). • Caregiver compliance with school recommendations for ameliorating any behavioral or academic concerns. • Whether caregiver is addressing behavioral issues through therapy or medication, e.g., medication for attention-deficit hyperactivity disorder (ADHD). • School adherence to IEP recommendations. <p><i>Note: caregivers are not mandated to use medication therapy for behavioral concerns.</i></p>

Determine if the child requires additional testing (if applicable).	<p>Determine if the caregiver has complied with any recommendations for testing:</p> <ul style="list-style-type: none"> • Hearing • Vision • Developmental Evaluation
Caregiver involvement or actions	<ul style="list-style-type: none"> • Determine if the caregiver attends teacher conferences, IEP meetings, suspension meetings, or meetings regarding the child's attendance.
Child's attitude	<ul style="list-style-type: none"> • Request information regarding the child's behavior, relationship with peers, and attitude towards learning.
Child's appearance	<ul style="list-style-type: none"> • Determine whether the child comes to school well-groomed, appropriately dressed, well-rested, and/or compliant with the school uniform policy (if applicable).
Determine if the school staff have any concerns of abuse or neglect of the child(ren).	<ul style="list-style-type: none"> • Inquire of the classroom teacher, school counselor or other appropriate school personnel whether they have had concerns regarding abuse or neglect of the child(ren).



REQUIRED TASKS FOR INTERVIEWING DAYCARE PROVIDERS

Required Task	Assess – Describe – Document
Child's attendance	<p>Determine and document the following information:</p> <ul style="list-style-type: none"> • How often the child attends daycare. • Any concerns related to the timeliness of the child's drop-off and/or retrieval from daycare.
Level of caregiver involvement	<p>Determine and document the following information:</p> <ul style="list-style-type: none"> • Caregiver response to daycare concerns. • Adequate and appropriate supplies for the child provided to the daycare.
Child's physical appearance	<ul style="list-style-type: none"> • Inquire about the child's cleanliness and hygiene. • Determine whether the child appears in good health or is brought to the daycare provider when ill. • Inquire about any history of unexplained or suspicious injuries.
Determine if there are additional concerns of abuse or neglect.	<ul style="list-style-type: none"> • Specifically discuss with staff whether they have had concerns regarding abuse or neglect of the child(ren).

REQUIRED TASKS FOR INTERVIEWING MENTAL HEALTH PROVIDERS

Required Task	Assess – Describe – Document
Mental health or behavioral issues for the child(ren)	<ul style="list-style-type: none"> • If the caregiver or school indicates that the child has any behavioral issues, e.g., suicidal or homicidal ideations, sexualized behavior (outside of age appropriate exploration), or other indicators of mental health issues, determine if the child has been referred for or received the appropriate evaluation or assessment. • Request information regarding the outcome of the assessment or evaluation, including any recommendations. • Determine if the parent or caregiver has followed through with the recommendations or referred services.
Medication prescribed for child's mental health issues	<ul style="list-style-type: none"> • Request information from the mental health provider regarding any prescriptions. • Request information regarding the caregiver's compliance with appointments, recommendations, and medication regimes. • If the caregiver has chosen not to medicate the child, what other services is the caregiver utilizing to address the child's behavior? <p>NOTE: it is not neglectful for a caregiver to refuse to give their child medication for a behavioral issue IF the issue is being addressed through another therapeutic intervention.</p>
Determine if the caregiver is exhibiting any signs of a mental health issue or has any diagnosed mental health conditions.	<ul style="list-style-type: none"> • Request information from the caregiver directly. • Document observations. • Contact any mental health providers currently involved with the caregiver. • If the caregiver is actively hallucinating or delusional, immediately contact the DC Department of Mental Health's Access Helpline at 1-888-793-4357 or MPD for assistance. • If applicable, contact the mental health provider to determine services and level of compliance.
Caregiver medications prescribed for mental health conditions	<ul style="list-style-type: none"> • Observe and document the number of medication bottle(s), types of medications, prescription dates, names and contact information (if available) for the prescribing physician(s).



REQUIRED TASKS FOR INTERVIEWING COMMUNITY SERVICE PROVIDERS

Required Task	Assess – Describe – Document
<p>Social services received through the community</p> <p>Determine whether these providers are relevant to the investigation.</p>	<ul style="list-style-type: none"> • Request information regarding any service provider involved with the family or children. • Contact the service provider to determine if they have any concerns regarding neglect or abuse. • Determine what services are being provided to the family. • Determine the family's level of compliance regarding service provision. • Ensure that you have an appropriate release form for receipt of the provider's information on the family.
<p>Healthy Family Thriving Communities Collaboratives</p> <p>Relevant services provided by Collaboratives</p>	<ul style="list-style-type: none"> • Contact the assigned family support worker to discuss any concerns regarding the caregiver or children. • Determine what services are being provided. • Discuss any new recommendations for service provision. • Contact the appropriate Collaborative if the family has received services in the past to determine if the family was compliant with services. • If the family was not compliant with services in the past, consideration should be given to opening a case within the Agency for low-to-moderate risk cases due to past non-compliance.

ALLEGATION-SPECIFIC INVESTIGATION STEPS

NEGLECT RELATED SUBSTANCE ABUSE OR DRUG ACTIVITY

EXPOSURE TO ILLEGAL DRUG ACTIVITY



General considerations

Illegal “drug-related activity” includes use, sale, distribution or manufacturing of a drug or drug paraphernalia without a legally valid license or medical prescription. Please familiarize yourself with *Drugs and their Effects* in section II of the appendix which discusses common aspects of drug manufacturing. You should also be aware that legal allegations regarding drug activity require “regular” exposure. This factor must be included in the assessment.

Most of our investigations of illegal drug activity result from police drug raids on residences or other locations. You should approach these investigations with the knowledge that there can be a complicated relationship between the CPS investigation and the ongoing MPD criminal case. At times MPD personnel may not want to give you full information for fear that it might be disclosed in the neglect case prior to MPD completing their own investigation. Because of this, two things are important:

- You need to be able to articulate specific needs for information pertaining to the CPS assessment; specifically information that substantiates the child is regularly being exposed to illegal drug activity. If you are not successful in your communication, contact may need to be made with the sergeant involved in the case or with your management team to determine next steps.
- At times, MPD personnel may be able to share information “off the record” that will help inform the CPS investigation. When there are difficulties eliciting information from MPD, you should consider whether there is “off the record” information that can be shared. You can then determine if/when the information will be useful to the CPS investigation. *“Off the record” information should not be documented in FACES but can be used toward an overall understanding of the family situation during the investigation.*

Assessment details

The following checklist is useful for ensuring that appropriate information is obtained during a drug raid investigation:

- How did the raid occur? (e.g., search warrant from undercover buy, search warrant from other information source, etc.)
- Who is the affiant or officer who signed off on the search warrant?
- What were the police specifically looking for? Who was the suspect?
- What, if any, drug(s) were found? Specify types, amounts, location.
- Could the children reasonably access the drugs?
- Photograph the drugs and/or locations where they were found.
- Was drug paraphernalia found? Specify types and location.

- Was the paraphernalia a danger to the children (such as chemicals)?
- Were weapons/ammunition found? Specify types and location.
- If a gun was found, was it loaded?
- Were the weapons accessible by the children?
- Photograph the guns and/or locations they were found.
- Often a drug raid results in physical upheaval of the home - you should ask the officers what condition the home was in prior to the raid. This information may be of concern.
- If there is discrepancy about the living situation of the suspect(s), determine if there are indicators to suggest that the suspect lives in the home (e.g., mail with the suspect's name and the address of the home, clothing of the suspect in the home, etc.)
- Be sure that you obtain the names and DOBs of all arrestees/persons involved in the raid whether they are family members or not. This will ensure that these individuals do not impede the investigation. If they present themselves as resources for the care of the children, their involvement will be factored into this decision.

Required tasks

- Drug testing for any child who was visiting or living in the raided environment. The child should have both urine and hair sample tests conducted. These tests can be completed at Children's National Medical Center upon your request.
- Pull the complete criminal history on the individuals involved in the investigation to determine any prior involvement with illegal drug activity.
- Speak to the affiant or the sergeant on the scene to determine if there is a history of other children frequenting the location of the drug activity or if there were other children at the scene at the time of the raid. Obtain the demographic information for these children/caregivers and create companion investigations.

SUBSTANCE-EXPOSED NEWBORNS

General considerations

Babies who are born exposed to illegal or non-prescribed prescription medication are some of the most at-risk children who come into contact with the child welfare system. Nationwide there are a variety of responses to these situations, including automatic removal by some state agencies due to the baby's inherent vulnerability combined with the obvious impairments of the caregiver who is struggling with substance abuse.

In the District, we do not hold a policy of immediate removal of these children or immediate open cases. In cases of newborn exposure to illegal drugs an allegation of substance abuse impacting parenting is entered at the CPS hotline. You, the CPS social worker, will conduct a thorough investigation and determine whether there is evidence that the substance use impacts the mother's parenting. In the event that you do not have sufficient evidence to suggest this you will still offer the family supportive services (see details below). At times, removal may also be warranted given the severity of the situation, which will be discussed in more detail below.

Remember that your approach to the caregiver involved is critical in obtaining accurate information for the purpose of planning for the safety of the child and assisting the caregiver. Remember, too, that despite the effects of, and behaviors related to, substance abuse, this habit or addiction often grows out of significant pain and trauma. Therefore, the engagement of the caregiver should not only involve acknowledgement of the facts but also the opportunities that the situation may present for positive change.

Assessment details

When completing an assessment regarding allegations of positive toxicology for newborns, one must consider several areas. The overall mosaic of the family should be considered, including the information below, to determine if it is reasonable to believe that the mother is and will be a sufficiently safe caregiver for a child. Removal should only be considered when a minimum basic level of care cannot be assured by the mother. You should make note of the following information:

- Type of drug used (please refer to the appendix *Drugs and Their Effects* for more detail)
You must determine the possible side effects that the drug may have on the mother. Consider that some drugs can have longstanding effects on functioning (e.g., the negative side effects of "flashbacks" can impair decision-making). Based on the type of drug used, you should also weigh the possible dangers of a relapse for the caregiver and the newborn.
- Frequency of use
Discuss with the mother the frequency and/or patterns of her drug use. Remember: whenever possible, statements made by caregivers need to be compared with other sources of information (CFSA/service

provider history, drug testing records, accounts of family members, etc.).

- **History of use**
Discuss also the mother's history of use and any periods of sobriety. Again, whenever possible, remember that statements made by caregivers need to be compared with other sources of information (CFSA/service provider history, drug testing records, accounts of family members, etc.).
- **Caregiver behavior related to use**
You need to understand that substance abuse does not happen in a vacuum. You must assess where and when the behavior occurs, where any children may be when this happens, and what other activity may be involved (prostitution, drug trafficking, etc.). All of these factors must be included in the overall assessment of, and planning for, the safety of the child.
- **Caregiver attitude toward use**
Begin to determine whether the caregiver acknowledges her use. This is often the first barrier to moving forward with an assessment. Given the positive toxicology screen this can be an easier discussion than in some other substance abuse investigations.

Further, talk with the mother about her willingness to participate in a drug test and substance abuse assessment. These are significant indicators of the Agency's ability to work with a caregiver around the serious issue at hand.

Determine whether the mother acknowledges that she has a problem. This, as the saying goes, is "the first step" to teaming with the mother to address the substance abuse issue.

Some mothers may not be immediately ready to admit their use so you should be prepared to take time to explain the options that exist for her should she elect to seek treatment. When faced with a mother who does not acknowledge her substance use, explain the significance of this and the difficulty that you face in even considering her child safe to go home without an acknowledgment that the use is occurring. You should also explain to the mother the potential consequences of not cooperating with both the assessment and the drug testing.

- **Caregiver preparation for, and attitude toward, having a baby**
Determine what planning and preparation the mother made for her child's birth. Some mothers may not have intended to keep the baby so conversation may need to be held about the mother's thoughts and feelings about the reality of the birth of the child. You also need to determine at what point the mother became aware of her pregnancy and compare this with the accounts and timeline of drug use.

Talk with the mother about whether she had prenatal care and find out the specifics details (e.g., provider location, frequency of visits, etc.). This information should be confirmed with the provider. Determine what other preparations the mother may have made for the birth of the child (e.g., obtaining appropriate supplies like a crib, diapers, etc.) and scheduling for services such as medical insurance or the District's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

- Support network

Father

Every child has a biological father and this should not be overlooked in your assessment. Talk with the mother about the identity of the father. At times the specific individual may not be known so as much paternal information should be gathered as possible, including any portion of a name or nickname, physical attributes, relatives of the father, last known whereabouts, places of employment, history of military duty, history of incarceration, etc.

Note: a father needs to be identified officially through a birth certificate, paternity testing, legal affidavit of paternity, or other method as noted in the General Considerations section of this guide. *You should never allow a child to be released to a father without legal identification of the father.* Once properly identified, a father may be considered as a care giving option after a thorough assessment regarding his desire and ability to care for the child, his support network, and whether there is any concern regarding substance abuse.

Extended family

Extended family support can be a key component to the overall safety of a child who might remain in the care of a mother who engages in substance abuse. Talk with the mother about her support network and any resources to assist her should she relapse. Contact needs to be made directly with these individuals to assess their ability to act as a viable support to the mother.

Required Tasks

1. Conversation with Hospital Staff and Review of Records

The hospital staff often has valuable information about family history as well as the current progress of the mother and child. You should review the family record to obtain a copy of the toxicology reports and pull other demographic information that may be useful during the course of the investigation, such as the mother's reported address, father's name, and so forth. Oftentimes mothers may have frequented the hospital during the pregnancy and there may be additional information regarding any substance

abuse history, the mother's planning for the pregnancy, or other helpful information. Ensure that you speak with hospital staff about this. Also, confer with the hospital staff about the mother's current bonding with the child and any concerns they may have about the family. Staff may not always seek out the CPS social worker so you must go to them.

2. Substance Abuse Assessment Referral

You must complete a substance abuse assessment referral for all investigations involving a positive toxicology screening for a newborn.

3. CFSA Nurse Referral (Office of Clinical Practice)

You must also complete a referral to the CFSA nursing staff for all investigations involving a positive toxicology screening for a newborn.

4. Zero-to-Three Early Intervention Referral

in accordance with federal law, all newborns with a positive toxicology must be referred to the 0-3 Early Intervention Program.

5. Safe Home Assessment

Ensure that the mother has a crib or safe sleeping arrangement for the baby. Ensure as well that the mother has supplies and a plan to have resources to feed, clothe, and shelter the baby.

6. Service Provision

If an allegation of substance abuse impacting parenting is substantiated you will consider the risk factors and determine whether an open agency or a collaborative referral would best serve this family; remember that collaborative services are always voluntary.

If an allegation of substance abuse impacting parenting is not substantiated, you will still offer ongoing supportive services to the family, either in the form of a voluntary CFSA case or a collaborative referral.

Be Prepared for any of the Following Possible Common Scenarios

- **Mother reports that she is living out of the jurisdiction.**

CPS social workers should never give consent for a discharge of a child without confirmation of the living plan and a full assessment that the child will be safe in a new jurisdiction. Unfortunately, not assessing this fully often leads to gaps in services that could have life-changing consequences for the

newborn. You must make a referral to the proposed jurisdiction and follow through to ensure that this is actually the planned living environment.

- **Mother tests positive but newborn does not.**

At times the Agency will be contacted by hospitals if a mother tests positive but the newborn does not. In these situations, if an investigation is assigned, the social worker should request that the hospital complete all possible tests for substances. One very useful test that is not always administered is testing of the meconium, the first stool sample of the newborn. It can be tested for exposure in utero to drugs and alcohol. This test can show information that is not always seen in standard urine testing.



MEDICAL NEGLECT INVESTIGATIONS

In addition to the steps you normally take during regular investigations, there are a few extra steps required when investigating reports of medical neglect. For an adequate medical neglect investigation, *you must indicate that you have made contact and completed an in-person or telephone interview with one or more of the child's medical providers.* These notes are important for the following reasons:

- Information and facts from interviews with medical professionals will help inform your disposition decision.
- A substantiated medical neglect allegation requires a medical opinion justifying the disposition

The disposition decision must be made in conjunction with one or more of the following medical professionals:

- CFSA nurse in the Office of Clinical Practice (OCP)
- Primary care physician
- Other physician(s) responsible for the well-being of the child
- Dentist
- Mental health professional
- Occupational or physical therapist

Referrals

You **must** make a referral to the CFSA nurses in OCP for every medical neglect investigation. The nurse referral form is located at the nurse's station in OCP. At a minimum, the referral should request a consultation, in addition to immunization and medical records. Such records may also be obtained from other sources of information as well (e.g., a school, private physician, etc.).



IDENTIFYING AND RESPONDING TO DOMESTIC VIOLENCE (DV)

What is Domestic Violence?

District law incorporates several phrases to describe domestic violence, including “interpersonal violence”, “intimate partner violence”, “intrafamily offense” and “intrafamily violence”.

Domestic violence is known to increase the threat of abuse to children. To protect child safety, you must carefully assess any incidents of domestic violence. Timely intervention is of the utmost

“Intrafamily violence” is defined by DC Code §16-1001(9) as *“an act punishable as a criminal offense that is committed or threatened to be committed by an offender upon a person to whom the offender is related by blood, adoption, legal custody, marriage, or domestic partnership, or with whom the offender has a child in common.”*

The DC Code §16-1001(6a-b) definition of “interpersonal violence” includes those *“with whom the offender shares or has shared a mutual residence; or who is or was married to, in a domestic partnership with, divorced or separated from, or in a romantic, dating, or sexual relationship with another person who is or was married to, in a domestic partnership with, divorced or separated from, or in a romantic, dating, or sexual relationship with the offender.”*

For purposes of this practice guide, the **definitions above collectively describe domestic violence (DV)**. As noted, it is not limited to marital relations. It can be specific to partnerships of varying types, including relations between former spouses, boyfriends and girlfriends, lovers, or those involved in emotional relationships without sexual involvement, e.g., violence among blood relations, e.g., adult siblings, or between an adult and an aging mother.

Domestic Violence Includes the Threat as Well as Actual Use of Violence.

Domestic violence is a social problem that affects every segment of the population. It crosses lines between race, socioeconomic status, religion, education, and gender.*It tends to be repeated with more frequency and more severity over time. *The presence of domestic violence in the home is known to pose significant risks to children!*

**Although the statistical majority of DV victims are women, there are cases of DV where the victims are men. Additionally, perpetrators of domestic violence can be women or men.*

As noted, research reveals that **exposure** to domestic violence in the home impacts child safety and well-being. Beyond watching or hearing the violent incident(s), exposure may include one or more of the following experiences:

- Direct involvement of the child (such as the child trying to intervene)
- Experiencing the build-up of tension prior to the violence
- Experiencing the aftermath of an assault (the child seeing bruises or observing parental depression)

Exposure to the negative, aggressive behaviors and attitudes that accompany domestic violence also increases the probability that children will copy those behaviors and attitudes. In other words, children who repeatedly witness domestic violence are more likely to use violence themselves to cope with or to resolve conflict.

NOTE: *Exposure to domestic violence does not, in and of itself, constitute abuse or neglect. Rather, CPS must assess and document whether domestic violence in the home has resulted in actual physical or mental injury or specific risk of harm to the children. Although CFSA will investigate domestic violence, its primary responsibility is to protect children and to conduct investigations that affect child safety. At times, removal of the children from a domestic violence situation is the only method to ensuring their safety after careful consideration of all family dynamics.*

Assessment

You should make every effort to gather the following information:

- Any knowledge of child(ren) intervening in DV incidents.
- Children showing signs of serious emotional distress that appear to be connected to domestic violence. For example, did symptoms such as bedwetting or behavioral problems begin or escalate following a violent incident?
- Influencing neglect of the child by either caregiver (e.g., the child is missing school, has lack of supervision, inadequate food or clothing, etc.).
- What is the nature of the current violent incident?
- Who is the primary aggressor or abuser?
- History, severity and frequency of violence in the home.
- History of police involvement.
- History of weapons in the home.
- Abuser's threats of death or bodily harm to self or others.
- Orders of protection or prior DV allegations in previous reports.
- Any past follow through on prior safety interventions.

As always, **documentation is necessary**, not only for proving allegations of child abuse or neglect, but for securing needed interventions, such as court-ordered services.

Record the abusive partner's words and actions in detail. Note in the case record any of the following coercive or controlling behaviors:

- Does the abuser become agitated, threatening or loud?
- Does the abuser interrupt or insult you?
- Does the abuser use threatening remarks, gestures or body language?
- Does the abuser interrupt constantly?
- Does the abuser blame or demean the survivor?

- Has the abuser directly or indirectly admitted any abusive or threatening actions and/or behaviors?
- How is the abusive partner's behavior harming the children?

Full documentation of domestic violence dynamics should include such additional elements as detailed information about the batterer's parenting, the full spectrum of the non-offending parent's efforts to provide for the safety and well-being of the children, and any other relevant information, e.g., finances, culture, substance abuse and/or mental health issues.

Unless there is evidence of child abuse and neglect on the part of the survivor, it is imperative that the case notes avoid language that in any manner judges, and/or states or implies blame on the part of the survivor. Avoid using language such as "dysfunctional family or mother "allows" or "enables" the violence, or mother" failed to protect" the children. Focus your case notes on facts specific to the abuser's actions, particularly in relationship to the harm and/or risk of harm to the children.

Required Tasks

In the event of a **credible** safety concern related to domestic violence, you must complete and attach an e-referral form for *Innovative Family Support Services* (IFSS) via email to the FTM unit in OCP *within 24 hours of the report*.

- You will be contacted by the CFSA DV specialist via email or telephone as soon as possible but no later than 48 hours upon the specialist's receipt of the IFSS form.
- If the client refuses services, the DV specialist will make a note of this fact and enter the information in the FACES contact screen.

Domestic Violence Safety Planning

Although the CFSA DV specialist may consult on a DV case, you play the vital role of working with the survivor and children to develop an immediate safety plan. For a safety plan to work, you will need to engage, involve, and collaborate with the survivor. Keep in mind that it may be unsafe for the survivor to write down the safety plan if the abuser is still living in the household. In such cases, the survivor should be encouraged to memorize the plan. As the investigator, you should document the plan in FACES and highlight the information as sensitive.

Important Factors that Impact DV Safety Planning

- Circumstances that have precipitated past DV incidents (alcohol, drugs, stress, arguments, weekends, etc.).
- **Past history of domestic violence incidents and the victim's response to those incidents.**
- The abusive partner's work schedule, location, and patterns.
- **Safest way to contact the family for future visits.**
- Identifying persons whom the victim can call or go to for help in an emergency (including 911).
- **Legal actions, such as a criminal protection order (CPO). *Note:* if a current CPO exists, copies**

should be distributed to the child(ren)'s school, day care center, and/or babysitter(s), after receiving written consent from the parent.

- Access to important items (car and/or house keys, birth certificates, social security cards, medications, cash, etc.).
- Available services – survivor should be given contact information to the DC Coalition Against Domestic Violence: 5 Thomas Circle, NW, 202-299-1181, www.dccadv.org
- Placement options for survivor and children - immediate shelter or a safe placement with friends or family. *Don't forget to follow the guidelines for safety planning with parents.*
- Police involvement (e.g., removal of all weapons from the house).

Note: Please see the **DV CPS Practice Points** in the Appendix for additional guidance and a list of service providers (including assistance for other language speakers). You will also find the MOU between CFSA and Survivors and Advocates for Empowerment, Inc. (SAFE) that notes the agreement for the provision of DV services in the appendix.

INVESTIGATIONS OF CHILD PHYSICAL ABUSE



The District of Columbia's 2003 **Memorandum of Understanding on Child Physical Abuse Investigation, Prosecution and Prevention** (2003 MOU) established a multidisciplinary team (MDT) of professionals to “work in concert” to address the needs of child victims of sexual abuse. Secondly, the team is required to focus on “law enforcement, prosecution and related civil proceedings, and third, “on the needs of the family members who support the best interests of the child.” The MDT includes but is not limited to representatives from CFSA, the Metropolitan Police Department (MPD), the Children's National Medical Center (CNMC), and the Children's Advocacy Center (CAC). In addition, there is a 2003 District of Columbia **Memorandum of Understanding and Inter-Agency Agreement on Child Maltreatment and Joint Investigations** (2003 IAA) that has helped to inform this section of the Practice Guide.

The following procedures are in compliance with the protocols listed in both the 2003 MOU and the 2003 IAA. In addition, you are expected to be familiar with and fully comprehend each of the following definitions and concepts:

The term “**physical injury**” means bodily harm greater than transient pain or minor temporary marks.

The term “**mental injury**” means harm to a child's psychological or intellectual functioning, which may be exhibited by severe anxiety, depression, withdrawal, or outwardly aggressive behavior, or a combination of those behaviors, and which may be demonstrated by a change in behavior, emotional response, or cognition.

The term “**abused**,” when used with reference to a child, means “infliction of physical or mental injury upon a child.”

Note: the meaning of the term “abused” does not include discipline administered by a caregiver to his or her child, provided that the discipline is reasonable in manner, moderate in degree and otherwise does not constitute cruelty.

REMINDER: the term "discipline" does not include:

- burning, biting, or cutting a child
- striking a child with a closed fist
- inflicting injury to a child by shaking, kicking, or throwing the child
- non-accidental injury to a child under the age of 18 months
- interfering with a child's breathing
- threatening a child with or using a dangerous weapon on a child (e.g. a firearm, knife, or any other prohibited weapon as identified in DC Code§22-4514

The above list is illustrative of unacceptable discipline *but is not intended to be exclusive or exhaustive*.

The term “**physical punishment**” is discussed in the 2003 IAA (based on case law). It notes:

In order for physical discipline to be acceptable, it must be administered by a parent as a considered response to misconduct and be applied in a tempered, controlled manner with as little violence and consequent possibility for actual physical injury as possible, given the age of the child and the attendant circumstances.

The 2003 IAA also discusses cultural differences in disciplining (based on case law) and notes:

Differences in disciplining children that are based on varying cultural or ethnic standards have no legitimate substantive role in determination of whether corporal punishment of children is reasonable or excessive.

Finally, the 2003 IAA discusses scenarios where physical abuse is suspected but physical evidence is lacking (based on case law):

A history of increasingly violent, almost reflexive parental reaction may well support a finding of abuse. Even where the specific incident, which brought the case before the court, did not result in an observably serious injury to the child, as the court must seek to protect the child from further risk of harm.

SCOPE

You are expected to work jointly with the MPD Youth Investigations Division (YID) to investigate allegations of child physical abuse where the alleged perpetrator is the child’s caregiver. You should also investigate caregivers who fail to protect a child in their care from child physical abuse or physical assault, even if the perpetrator is not acting *in loco parentis*. These investigations encompass allegations that occur in the District of Columbia, regardless of the location of the child’s primary residence.

INVESTIGATION LEAD

As a general rule, the assigned YID detective takes the lead for investigating and assessing serious physical injury/abuse allegations involving children. CFSA maintains primary responsibility only in matters that are not designated as immediate or serious physical injury/abuse.

It is important for you to remember that response times for YID investigations and CFSA investigations do not always coincide. Since the MOU indicates that YID takes the lead on some physical abuse investigations, you must make contact with YID prior to initiating an investigation of a serious or immediate allegation. When you do make contact, you will want to discuss whether YID is responding, and your plan for ensuring the children’s safety without compromising the criminal investigation.

The interview with child(ren) who may have been physically abused should follow the same components discussed in *general child interviewing requirements*. You will also want to gather the following information to

assess the entirety of the child's situation:

- The nature, extent, and cause of the abuse or neglect
- The identity of the person responsible for the abuse or neglect
- The name, age, social security number and address of all parents of victim(s) and/or sibling(s)
- The name, age, sex and condition of the abused or neglected child and all other children in the home
- The conditions of the home at the time of the incident
- Whether there is any child in the home whose health, safety, or welfare is in jeopardy because of his or her treatment in the home or his or her home environment
- Whether any child who is in jeopardy because of treatment in the home or his or her home environment should be removed from the home or can be protected by the provision of resources

If the child makes a disclosure during this interview that impacts their immediate safety, you should contact YID to determine what, if any, immediate role they may need to play.

Special Note: care should always be taken to minimize the number of times a child is interviewed so as not to exacerbate the child's trauma.

YID may at times determine that the reported allegation does not meet their standard for an investigation, and will therefore it will be turned over to CFSA. In those situations, you are the lead and sole investigator of the allegations. If, however, during the CPS investigation, additional detail or allegations are discovered that may suggest the need for a criminal investigation, these should be discussed with your management team and forwarded to YID for assessment.

PRIMARY ASSESSMENT OF PHYSICAL SAFETY AND MEDICAL EXAMS

Special Note: a child should never be transported for a medical examination by the alleged perpetrator of physical abuse.

When assessing a physical abuse allegation, you must first begin by ensuring that the child is not in need of immediate medical treatment. If a child is complaining of significant pain or has other visible indicators of immediate injury, you must contact 911.

Purpose

There are a number of reasons that medical examinations occur in physical abuse investigations:

- To assess the physical well-being of the child(ren).
- To gather any physical evidence of a crime of physical abuse.
- To provide the child(ren) with an opportunity to disclose during the examination. *Note: disclosure to the medical provider may be able to be used in court.*
- To reassure the child(ren) about his or her body.

Location



Children's National Medical Center (CNMC) houses the Freddie Mac Child and Adolescent Protection Center (CAPC), which specializes in assessing and treating victims of child maltreatment. CNMC, and specifically the CAPC, is the preferred provider for these evaluations. Families may elect, however, to have the child(ren) seen at another provider. You and the detective are obliged to explain to family members the benefits of having the child seen by a specialist at CAPC. You and the detective are also expected to facilitate the process, ensuring to the best of your ability that professional evaluations have taken place.

REMINDER: in instances of immediate medical evaluation or follow-up medical evaluation, CAPC is the preferred provider.

PHYSICAL OBSERVATION AND DOCUMENTATION OF INJURIES

In many instances of physical abuse allegations, the matter will not require a medical evaluation by CAPC or other medical professional. In instances of minor or no injuries, you may be able to adequately record the injuries (or lack thereof) without the need of a medical professional.

In the event that the injuries are not visible, your assessment must consider one or more of the following potential reasons that injuries are not present:

- No injury ever occurred.
- An injury occurred but bruising is not yet manifest on the child's body.
- An injury occurred but is no longer visible.
- An internal injury occurred that is not visible to the eye.

When an injury does not appear to have ever occurred related to physical abuse, you must document this in FACES. Ideally, you will be able to demonstrate that no injury exists by photographing the area of the body where the alleged injury occurred. You should also be mindful that depending on how quickly you respond to a notification of alleged abuse, bruising and swelling may not always occur immediately. Follow up may be needed to determine whether visible injuries develop. (This is also true in situations where a child may have some injuries immediately present but others develop in the coming days.)

In instances where an injury may have faded or healed, you must, whenever possible, converse with the child

about this injury, and describe in your FACES documentation how the injury appeared at the time of the event as well as any related pain or impairment in functioning that was a result of the injury.

If there is any concern for an internal injury, a medical examination should occur. For example, a child who is punched with force in the abdomen may be suffering from damage to the organs, or other internal injuries even though there is no visible, external injury. In the event that there are observable injuries, you must take care to describe each injury in detail (size, shape, color, etc.) in FACES. You should also photograph each injury. In doing so, it may be helpful to have a measuring tape or some other standard (dollar bill, coin, etc.) to hold next to the injury to demonstrate the nature and extent of the injury.



NOTE: CFSA Has Legal Authority to Take Photographs and To Require Radiological Examinations (DC Code § 4-1301.08)

Any person responsible for the investigation may take or have someone take photographs of each area of possible trauma on the child or of the conditions surrounding the suspected abuse or neglect of the child. If medically indicated, you may also request that the child have a radiological examination, including full skeletal x-rays.

CHILD ADVOCACY CENTER (CAC) INTERVIEW

Criteria for CAC Interviews

Whenever there is an allegation of child physical abuse, the following categories of children are required be interviewed at the CAC, unless the prosecutor and detective have determined that a CAC interview is unwarranted:

- Any child **aged 5 years or younger** who has any of the following injuries:
 - Suspicious burns
 - Suspicious head injuries
 - Injuries with an implausible explanation
 - Injuries of different ages which are indicative of a pattern of abuse
 - Suspected Munchausen Syndrome by Proxy

- Adult-sized bites
- Other serious injuries that involve hospitalization or surgery
- All other children **aged 12 or younger** who may be a witness to the physical abuse of a child victim or to a child fatality caused by abuse.
- All other children **aged 12 or younger** who live in the same household as a child victim discussed above, if the lead detective believes a criminal prosecution is likely to occur.

Note: while a forensic interview at the CAC may not be required in all cases, detectives and CFSA investigative social workers are encouraged to utilize the CAC whenever it may assist the investigation or help to better serve the needs of child victims or witnesses.

Scheduling

Any MDT member may schedule a CAC interview *but the primary responsibility for scheduling is that of the assigned detective*. **Note:** since all MDT members are committed to coordinating the scheduling of these interviews to accommodate one another, all parties who are directly involved with the investigation are expected to be present for the interview.

- CAC interviews should be scheduled, whenever possible, on the same business day as the report.
- When the initial CPS assessment suggests that a CAC interview is immediately warranted, this should be elevated and addressed through your chain of command.
- At times, a CAC interview may be required after the close of standard business hours due to emergency circumstances. In such instances, the assigned detective may contact the on-call interviewer from the CAC to conduct the interview.
- If the initial CPS assessment suggests that a CAC interview is immediately warranted and there are concerns regarding scheduling, this should be elevated and addressed through your chain of command.

Counsel Notification of a CAC Interview

- When a child is represented by counsel (aka a guardian ad litem), this counsel must give consent for the interview and has a right to be present.
- If you have knowledge of counsel for a child or if a child has been removed please ensure that this information is shared during the scheduling.

Transportation

- Coordination of transportation is the responsibility of the MDT member scheduling the interview. In general, this will be the assigned YID detective.
- The MDT members should always endeavor to work together to address transportation.

Decision Not to Hold an Interview

- The MDT may determine in any given matter that a CAC interview is not necessary or warranted.
- At times, an interview may not be held due to unaddressed mental health needs of the child. If the child is currently receiving therapeutic services, coordination is required to occur between you, the CAC, and the service provider to determine if an interview is appropriate. If no services are in place, the CAC may be scheduled at a later date, after therapeutic services are in place.
- The average age for CAC interviews is 3-12 years old. There are times, however, when the MDT will determine that a detective can successfully interview a teenager in an environment outside of the CAC. If you believe that the environment at the CAC would be most appropriate to ensure the teenager's well-being, you should advocate for the teen and request that the interview take place in the CAC environment. *Keep in mind that the MDT has no other child-friendly location for the purposes of recording an interview.*

Unexplained or Inconsistent Injuries

General considerations

A CPS investigation is warranted when a child has a serious injury and one of the following circumstances exists:

- No explanation is provided but an explanation should be available, given the type of injury (e.g., serious bruising, lacerations/abrasions, burns, bite marks, fractures, etc.)
- An explanation is provided but it is inconsistent with the injury,
- Multiple explanations are provided but statements are inconsistent.

Assessment Details

- **Detailed Timeline**

In collaboration with the MPD detective, the social worker should obtain a detailed timeline (whenever possible) of any events precipitating and/or surrounding the child's injury, including the following information:

- * physical location(s) of the child
- * feeding/sleeping patterns (if a small child)
- * persons responsible for the care of the child
- * persons with access to the child
- * demeanor/behavior of the child, including anything out of the ordinary
- * any history of falls, injury, or other unusual incidents

- **Assessment for neglect**

If an unexplained injury is ultimately determined to be accidental, assessment should still occur to ensure that there are not any neglect factors, such as supervision concerns.

- **Removal Discussion**

Removal of a child should be considered under the following circumstances:

- * A child has an unexplained injury that is indicative of abuse.
- * A child has an unexplained injury that could be accidental but, if accidental, would have been memorable enough to be able to relate the circumstances around the injury.

If it can be determined that the injury occurred outside of the responsibility of the primary caregiver, removal may not be necessary. You must still make a very thorough assessment to ensure that the primary caregiver used/uses appropriate judgment in the care of the child and is able to protect the child in the future.

Required tasks

- [Medical Examination/Medico-Legal](#)

In matters involving unexplained injuries that are suggestive of possible child abuse, you must ensure that a medical examination takes place. Depending on the severity of the injury, this examination may need to occur immediately to ensure safe planning for the care of the child. Ideally, these examinations will occur at the CNMC Child and Adolescent Protection Center.

CHILD FATALITY INVESTIGATIONS

General considerations

Child fatality investigations and “near-fatality” investigations are, by nature, high-profile and sensitive. The CPS Special Abuse Unit will usually investigate these matters in collaboration with the MPD Special Victims Unit (SVU). It is important to realize that many child deaths are officially found to be of natural or undetermined causes. Be very mindful that even accidental or undetermined deaths can be associated with neglect factors (e.g., poor supervision, inadequate sleeping arrangements, caregiver substance abuse, etc.). At other times, you will find yourself working with the police on abusive deaths due to homicide.

Be mindful as well that a specific allegation of abuse or neglect is not required for CPS investigations into child fatality matters. The following scenarios are possible:

- Hotline call reflects allegations of neglect or abuse that must be dispositioned through investigation.
- Hotline call does not reflect allegations of neglect or abuse but due to the uncertain nature of the child’s death a CPS assessment is warranted.
 - Allegations may be discovered during the course of the assessment, be added to the investigation, and be dispositioned prior to closure of the investigation.
 - No abuse or neglect concerns surface during the investigation and the investigation is closed without needing entry or disposition of allegations after appropriate assessment and service provision.

Assessment details

- **Observation of the Decedent**
In most child fatality investigations, you will be responding to the location of the decedent to observe the child and gain an initial understanding around the child’s death. You should observe the child, in collaboration with hospital staff or police to determine if there are injuries or other notable factors (such as the child’s hygiene, physical appearance, etc.).
- **Interview with Emergency/Hospital Personnel**
You should speak with hospital personnel regarding the child’s method of transport to the hospital, the initial impressions of the parent/caregiver, the history taken by hospital staff around the child’s death, and any other pertinent information. Remember to make note of and record the initial impressions of the hospital staff regarding the child’s death and use this as a foundation for the assessment.
- **Detailed Time Frame around Death**
Request a detailed timeline of events around the child’s death and any precipitating events. You should team with the MPD detective to gather the following information:

- * Physical location(s) of the child

- * Feeding/sleeping patterns (if a small child)
- * Persons responsible for the care of the child
- * Persons with access to the child
- * Demeanor/behavior of the child, including anything out of the ordinary
- * Any history of falls, injury, or other unusual incidents

- **Details of the Mother's Pregnancy and the Child's Birth**

An interview should be held with the mother and/or other caregiver around the pregnancy and birth of the child to gather the following information:

- * Prenatal care
- * Pregnancy complications
- * Type of delivery and any complications
- * Pre or full-term birth and birth weight

- **Details of the Health, Development and Basic Care of the Child (including sleeping and feeding of young children)**

Your assessment should include details of the child's health history (or if a "near fatality", then current health), including any diagnosed conditions, medications, the child's primary doctor, and any medical examinations. You should also discuss with the caregiver whether the child was (or is) meeting the standard developmental milestones. Further, the basic care of the child should be discussed, including the feeding/sleeping patterns of young children.

- **Family Health History**

Determine if there is any pertinent family history of disease or illness that could be related to the child's death.

- **Details of Autopsy Findings**

An autopsy is conducted for most child fatality investigations. The SVU detective, and often a detective from YID, will attend the autopsy. Typically the autopsy is conducted within a few days of the death and the detective will share with you the initial autopsy findings. These details can be vital to your overall investigation. They may, for example, reveal additional bruising or internal injuries not observable at the time of the child's death.

- **Cause of Death vs. Manner of Death**

"Cause of death" is the chain of events that led up to the death (such as cardiac arrest, complications of disease, etc.). The "manner of death" falls into one of five categories: natural, suicide, homicide, accidental, or undetermined. Due to the length of time required for a full autopsy report, the cause and manner of death may not be officially determined when you are in the process of determining whether or not to close the investigation. If this takes place with your investigation, you should consult with your management team to decide whether there is sufficient information for a safe closure of the investigation.

without the official report. It may be that the initial autopsy findings will be sufficient to make your determination for a safe closure.

Required Tasks

- **0-3 Early Intervention Referral**

In the event of a child fatality where there are surviving children (age 0-3) in the family, you are required to refer these infants/toddlers for a preventive early intervention screening.

- **Medical Assessment of Siblings**

When a child dies in unknown or suspicious circumstances, any surviving siblings should be medically assessed. In investigations involving unexplained injuries or abusive death, a medico-legal screening should be obtained. It is preferred that the assessment occur at the CNMC Child and Adolescent Protection Center.

- **OCP Nurse Referral**

A referral to CFSA's OCP nurses is mandatory in any child fatality investigation.

- **Assistance for Death Notification**

You should offer assistance to families for the notification of death in all child fatality investigations. The clinical coordinator at the CAC and staff at the Wendt Center are excellent resources. Make certain that the family members are emotionally ready and equipped to have this conversation. In matters involving abuse/neglect, you should ensure that professionals take the lead in such discussions so there is no additional trauma to the child(ren).

- **Offer of Grief Counseling**

It is your responsibility to offer referrals for grief/loss counseling to family members involved in child fatality investigations.

- **Offer Funeral Assistance**

If a family has open involvement with CFSA, the Agency may assist financially with funeral arrangements for the decedent. Please check with your supervisor regarding this process and the availability of funds. If the family has no involvement with CFSA, you should meet with the family to assist them in accessing public services for funeral arrangements. This can be done through their neighborhood collaborative or

the Department of Human Services.

- **Critical Event Meeting**

You and your management team will work together with other Agency staff during a critical event meeting to discuss the status and next steps of this investigation. This meeting will be coordinated and facilitated by Quality Assurance personnel from CFSA. This meeting is typically held within 24 business hours of the critical event.

- **CFSA Internal Child Fatality Review**

This meeting typically occurs several weeks after a child fatality investigation is completed. Your participation is required along with members of the CPS management team. At this time agency history with the family will be reviewed as well as details around the child fatality. The following areas are topics of discussion:

- Did CFSA take every action and make every reasonable effort to ensure the safety of the child and other children in the household?
- Are there any practice, training or policy issues that need to be resolved as it relates to the respective child fatality? What are other systemic issues such as supervision, staffing, access to records etc.?
- Knowing what we know now, what would we do differently?
- What are the interagency issues to present to City-Wide Child Fatality Review Committee?
- Were there parental or familial behavior factors that contributed to the fatality?

SEXUAL ABUSE INVESTIGATIONS AND EVALUATIONS

OVERVIEW

As noted in the section on **Physical Abuse**, the 2003 MOU established a multidisciplinary team (MDT) of professionals to “work in concert” to address the needs of child victims of sexual abuse. Secondly, the team is required to focus on “law enforcement, prosecution and related civil proceedings, and third, on the needs of the family members who support the best interests of the child.” *Reminder: The MDT includes but is not limited to representatives from CFSA, MPD, the Children's National Medical Center (CNMC), and the Children's Advocacy Center (CAC).*

The following procedures comply with all protocols listed in the 2003 MOU regarding child sexual abuse investigations and evaluations. It is further useful and expected that you become familiar with and fully comprehend each of the following definitions:

“Sexual Abuse” DC Code § 16-2301(32)

- (A) Engaging in, or attempting to engage in, a sexual act or sexual contact with a child (see definitions of “sexual act” and “sexual contact”);
- (B) Causing or attempting to cause a child to engage in sexually explicit conduct (see definition of “sexually explicit conduct”); or
- (C) Exposing a child to sexually explicit conduct (see definition of “sexually explicit conduct”).

“Intra-familial” Offense DC Code § 16-1001

An act punishable as a criminal offense committed by an offender upon a person:

- (A) to whom the offender is related by blood, legal custody, marriage, having a child in common, or with the offender shares or has shared a mutual residence; or
- (B) with whom the offender maintains or maintained a romantic relationship not necessarily including a sexual relationship.

“Sexual Act” DC Code Section 16-2301 (34) and 22-3001 (8)

Penetration, however slight, of the anus or vulva of another by a penis; (b) contact between the mouth and the penis, the mouth and the vulva, or the mouth and the anus; or (c) the penetration, however slight, of the anus or vulva by a hand or by any object, with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person. The emission of semen is not required for the purposes of subparagraphs (a) – (c) of this paragraph.

“Sexual Contact” DC Code Section 16-2301 (35) and 22-3001 (9)

The touching with any clothed or unclothed body part or object, either directly or through the clothing, of the genitalia, anus, groin, breast inner thigh, or buttocks of any person with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person.

For the purpose of CPS investigations, *child sexual activity* is defined as sexual behavior that is considered developmentally precocious or inappropriate and/or potentially symptomatic of a child who has been sexually abused.

In addition to being familiar with the relevant terminology, you must also be familiar with the following components of investigation and the evaluation procedures:

- The overall scope of investigations and evaluations
- Individual roles and responsibilities for different members of the MDT
- Conversations with non-offending caregivers
- Medical examinations (purpose, location, etc.)
- CAC interviews (including the decision not to hold an interview)
- Handling of historical allegations
- Required investigation tasks and FACES documentation

It is also important to recognize the legal limitations of CFSA's responsibility, i.e., *you may only investigate allegations against a caregiver acting in loco parentis*. Notwithstanding this limitation, the Agency is still responsible legally and professionally for ensuring the safety of children in the District of Columbia. Therefore you must still conduct *safety evaluations* involving intra-familial sexual abuse and/or reports of child sexual activity. If, however, allegations against a caregiver are identified during the course of an evaluation, the matter should then be converted into an investigation.

The overall section on sexual abuse is divided into the following categories:

- Investigations of Child Sexual Abuse
These are matters involving allegations of child sexual abuse of a minor victim (at the time of offense) by a parent or caregiver acting in loco parentis.

An example of this is a child who was sexually abused by her father.

Another example would be a child who was sexually abused by an aunt who is the child's primary caregiver and acting in loco parentis.

- Safety Evaluations of Intra-Familial Child Sexual Assault

These are matters involving sexual abuse of a minor victim (at the time of offense) by a family member who is not a parent or a caregiver acting in loco parentis.

This includes offenses on children by adult family members who are not parents or who do not play a caregiving role for the child. An example of this might be an uncle who resides in the home but is not acting in loco parentis.

This also includes offenses on children by relatives who are minors. If there is force involved in the assault there is no required age difference between the children. If the activity was “consensual” there is a four year age difference required between the victim and perpetrator to consider this an assault investigation. An example of this would be a 13 year old who forcibly rapes his 12 year old cousin. Another example of this would be a 17 year old who is having “consensual” sex with her 12 year old brother.

- **Safety Evaluations of Child Sexual Activity**

These matters include behaviors, statements, or other indications of developmentally inappropriate sexual knowledge suggestive of potential child sexual abuse. If more than one child is involved, such activity must have occurred between children with less than a four-year age difference (unless force is involved- see above).

Evaluations of such matters do not require an intra-familial relationship between the children, nor do the children involved need to live in the District. If the report alleges that the child sexual activity occurred in the District, CFSA will evaluate for the safety and well-being of the child. If concerns develop during the course of the evaluation regarding any failure to protect or any other maltreatment by a caregiver acting in *loco parentis*, the evaluation must be converted to an investigation and the appropriate allegations added to FACES.

When working with a “[child on child](#)” sexual activity evaluation, a primary evaluation is taken regarding the family of origin of the alleged perpetrating child (if one can be determined). It is your responsibility to carefully assess whether the perpetrating child has suffered sexual abuse and/or whether there are any children at risk for being exposed to the perpetrating child.

- Under such circumstances, the alleged victim child is assessed as a collateral source of information to the evaluation.
- You and your management team have the discretion to determine whether the situation warrants further intervention, and/or whether to enter a companion evaluation or investigation regarding the victim child’s family of origin.

- **Safety Evaluations of Suggested Sexual Abuse**

These matters include [circumstances which are only suggestive of sexual abuse that may have](#)

occurred or potentially will occur. Children living under the following situations may be victims of sexual abuse and/or vulnerable to potential sexual abuse:

- Exposure to adult sexuality (for the sexual gratification of the perpetrator)
- Residing with a sexual offender
- Sexual exploitation of the child (pornography, prostitution, etc.)
- Other risk factors related to sexual abuse

Reports on any of the above situations may be accepted on a case-by-case basis and should be discussed amongst the CPS management prior to acceptance for evaluation.

Note: Allegations that a child is exposed to sexual activity (live or simulated) by a caregiver are only taken as sexual abuse safety evaluations IF the alleged perpetrator was intentionally exposing the child for their own sexual gratification. All other matters may be investigated as general neglect and are handled by traditional units.

INVESTIGATIONS OF CHILD SEXUAL ABUSE

Scope

In accordance with the 2003 MOU, you are expected to work jointly with the MPD Youth Investigations Division (YID) to investigate allegations of child sexual abuse where the alleged perpetrator is the child's caregiver. You will also investigate caregivers who fail to protect a child in their care from child sexual abuse or sexual assault, even if the perpetrator is not acting *in loco parentis*. These investigations encompass allegations that occur in the District of Columbia, regardless of the location of the child's primary residence.

Investigation Lead

As a general rule, the assigned YID detective takes the lead for investigating and assessing sexual abuse allegations involving children. There is, however, a standing agreement that an immediate joint investigation shall occur when a report includes information that an alleged perpetrator lives in the same home of the alleged victim, or has regular access to the child victim, which subsequently indicates a potential immediate danger to the child. In such instances, you should communicate as soon as possible with YID for commencing the joint investigation accordingly.

SPECIAL NOTE: alleged perpetrators may also be minors who live in the same home *and may pose an equal level of danger*. If information about access between a perpetrator and a child is discovered during the investigation, this should be discussed with your management team and forwarded to YID for intervention.

It is important for you to remember that response times for YID investigations and CFSA investigations do not always coincide. Since the 2003 MOU indicates that YID takes the lead on sexual abuse investigations, you must make contact with YID prior to initialing your report to discuss whether they are responding and to discuss your plan for ensuring the children's safety without compromising the criminal investigation.

When you are not able to conduct a joint investigation because a detective has not been assigned, you should not directly discuss the sexual abuse allegations with the caregivers or child(ren). Doing so may compromise the future police investigation by prematurely disclosing sensitive information. In these cases, ideally, the child(ren) should be interviewed at school or in another neutral environment. If the children must be interviewed at home, which obviously informs the caregiver of the investigation, you should explain that the Agency has received a complaint regarding the safety and well-being of the child(ren) and that you are there to assess the safety and well-being of the family. In some situations, you may need to provide some information to the caregiver in order for the caregiver to protect the child (e.g., if the uncle is the alleged perpetrator and he visits the home sometimes, the caregiver can be put on alert).

The interview of the child(ren) should follow the components discussed in the *general child interview*, including a preventive assessment for sexual abuse. If the child makes a disclosure during the interview that impacts

their immediate safety, you should contact YID to determine what, if any, immediate role they may need to play.

***Special Note:** care should always be taken to minimize trauma by limiting the number of times a child must be interviewed.*

YID may at times determine that the reported allegation does not meet their standard for an investigation. In these types of situations, you are the lead and sole investigator of the TOT'd allegations. If, however, during the CPS investigation, additional detail or allegations are discovered that may suggest the need for a criminal investigation, you should consult with your management team and forward the information to YID for assessment.

Conversation with Non-Offending Caregiver

When a child has been sexually abused, there may be a non-offending and/or protecting caregiver involved. You must take care to thoroughly assess the non-offending caregiver's ability and willingness to ensure the safety of the child and to follow through on needed services for the child. Written safety planning is a crucial component for maintaining stability for a child victim in these situations. Safety planning should be used anytime that a child remains with a non-offending caregiver. All details of the plans should be written down. You, the caregiver, and your supervisor should all sign the safety plan. In addition, *please consider the following factors when assessing the caregiver's ability to protect the child both physically and emotionally:*

- Prior knowledge of the sexual abuse and the possibility of a lack of protection by the non-offending caregiver
- Non-offending caregiver's knowledge of previous deviant sexual behavior by the alleged perpetrator, which may present a danger to a child(ren)
- Attitude of the caregiver toward the victim child, alleged perpetrator, and allegations
- Willingness of the caregiver to ensure that the perpetrator does not have access to the child, including obtaining a protective order
- Willingness of the caregiver to participate in ongoing services for the child, including the CAC interview, medical examination, and therapeutic services

When discussing the investigation with a non-offending caregiver, care should be taken to instruct this individual on appropriate interaction with the child and alleged perpetrator. The caregiver should not unduly discuss the investigation with the child. The alleged perpetrator should not be informed of the investigation, nor should the caregiver confront the alleged perpetrator about the allegations.

In situations where the alleged perpetrator is an adult, the non-offending caregiver must agree in writing that the alleged perpetrator will leave the home (if applicable) and further, that the alleged perpetrator will not have any access to the alleged victim or other at-risk children in the family.

Medical Examination

Purpose

There are a number of reasons that medical examinations occur in sexual abuse investigations:

- To assess the physical wellbeing of the child(ren).
- To gather any physical evidence of a crime of sexual abuse.
- To provide the child(ren) with an opportunity to disclose during the examination. **Note:** *disclosures to the medical provider may be able to be used in court!*
- To reassure the child(ren) about his or her body.

Special Note: *a child should never be transported for a medical examination by the alleged perpetrator of sexual abuse.*

Location



The Children's National Medical Center (CNMC) houses the Freddie Mac Child and Adolescent Protection Center (CAPC), which specializes in assessing and treating victims of child maltreatment. CNMC, and specifically the CAPC, is the preferred provider for these evaluations. Families may elect, however, to have the child(ren) seen at another provider. You and the detective are obliged to explain to family members the benefits of having the child seen by a specialist at CAPC. You and the detective are also expected to facilitate the process, ensuring to the best of the family members' ability that professional evaluations have taken place.

When Sexual Abuse is Reported to have Occurred Within the Last 72 hours or When the Child is Unable to Articulate a Time Frame

Children who have suffered sexual abuse or assault within the last 72 hours should be seen for immediate medical attention.

- You and the YID detective should assist any non-offending caregiver with this process.
- The YID detective will take responsibility for coordination of an exam by a sexual assault nurse examiner (SANE) and will be responsible for the "sex kit" (if one is to be completed.) **Special Note:** *the sex kit is considered legal evidence and is subject to chain of custody rules involving the police department and the hospital.* You should never take possession of a sex kit (including transport to the hospital).
- Similarly, you should never take possession of the original "medico-legal" form that has been completed by a physician in sexual assault examinations. This, too, is considered a legal document and is subject to chain of custody regulations. However, you must obtain a **copy** of the "medico-legal" document for use in the CPS investigation and any family court proceedings in which CFSA is involved.

Working with the Caregiver

- If a caregiver is unwilling to take steps to have the child(ren) examined, you and the detective must make every effort to explore and alleviate any of the caregiver's concerns. It is a good idea to reiterate the important reasons for this immediate examination.
- **Reminder:** sexual abuse and sexual assault disclosures are typically traumatic, not only for the child but also for the non-offending caregiver. It is important that you allow the caregiver an appropriate measure of time to process the information while simultaneously striving to empower the caregiver to make the best decisions for the well-being of the child. You should assist the caregiver in managing their emotions and composing themselves so as to minimize trauma to the child and to allow the parent to provide appropriate support to the child.
- If a caregiver remains unwilling to allow for the medical examination, then you must inform the caregiver (without coercion) that this may be grounds for a finding that the child is without proper parental care and/or without the control needed to ensure the child's safety. If concern persists regarding completion of the medical examination, this should be discussed with the caregiver and your management team as there may be a need to take custody of this child to ensure that this examination occurs and the child's well-being is addressed.
- When an initial examination has successfully taken place, you and the YID detective should also assist the family with any follow-up care that may be needed, such as further testing and/or therapeutic services and determine the outcome.

When Sexual Abuse is Reported More than 72 Hours After the Alleged Occurrence

The following shall occur within 48 hours of the report:

- All children 12 years of age or younger alleging any type of sexual abuse or contact must be taken for an examination. YID will use its discretion as to whether a sex kit is required.
- All children between the ages of 13 and 17 who allege any penetration, attempted penetration, oral-genital or anal offense shall be taken for a sexual assault examination. YID will provide sex kits in all of these cases.
- When a child over age 12 alleges sexual abuse by fondling, YID will use its discretion as to whether a medical examination is warranted.

When there is No Disclosure

When an investigation alleges sexual abuse, but there is no disclosure by the child at any time, there is still a possibility that sexual abuse occurred, even without evidence. It is the Agency's practice to recommend that a child who does not disclose still be taken for a medical examination. If you are unsure whether or not to recommend a medical examination, please consult with your supervisor for immediate guidance.

CAC Interview

Criteria for CAC Interviews

Unless the prosecutor and YID detective have determined that a CAC interview is unwarranted, the following categories of children should be interviewed at the CAC when there is an allegation of child sexual abuse:

- Any child **under** age **12**, or
- Any child over age 12 with the following qualifiers:
 - an intra-family relationship with the offender
 - emotional, developmental, learning or other disabilities
 - alleged victim is non-communicative on the scene

Scheduling

Any MDT member may schedule a CAC interview *but it is the primary responsibility of the assigned detective*. **Note:** since all MDT members are committed to coordinating schedules with one another for the interviews, all parties who are directly involved with the investigation are expected to be present.

- CAC interviews should be scheduled, whenever possible, on the same business day as the report.
- When the initial CPS assessment suggests that a CAC interview is immediately warranted, this should be elevated and addressed through your chain of command.
- At times, a CAC interview may be required after the close of standard business hours due to emergency circumstances. In such instances, the assigned detective may contact the on-call interviewer from the CAC to conduct the interview.
- If the initial CPS assessment suggests that a CAC interview is immediately warranted and there are concerns regarding scheduling, this should be elevated and addressed through your chain of command.

Counsel Notification of a CAC Interview

- When a child is represented by counsel (aka a guardian ad litem), this counsel must give consent for the interview. He or she has a right to be present.
- If you have knowledge of counsel for a child or if a child has been removed, please ensure that this information is shared during the scheduling.

Transportation

- Coordination of transportation is the responsibility of the MDT member scheduling the interview. In general, this will be the assigned YID detective.
- The MDT members should always endeavor to work together to address transportation.

Decision Not to Hold an Interview

- The MDT may determine in any given matter that a CAC interview is not necessary or warranted.
- If the MDT determines that a CAC interview is not needed in a sexual abuse matter, notification should still be made to the CAC to ensure coordination of services, follow-up with the child and family, and systems record maintenance.
- At times, an interview will not be held due to a child's unaddressed mental health needs. If the child is currently receiving therapeutic services, coordination may be necessary. It will be up to you, the CAC, and the service provider to determine if an interview is appropriate. If no services are in place, the CAC may be scheduled at a later date, after therapeutic services are in place.
- *Remember: the CAC usually interviews children under age 13.* There are times, however, when the MDT will determine that a YID detective can successfully interview a teenager. If you believe that the environment at the CAC would be the most appropriate to ensure the teenager's well-being, you should advocate for the interview to be held there. Keep in mind that the MDT has no other child-friendly location for the purposes of recording an interview.

Historical Allegations

- CFSA does not have a statute of limitations for reports of sexual abuse. Nonetheless, there are such limitations within the criminal system. You need to be prepared in such instances to investigate historical situations without police assistance.
- When considering historical allegations, you must not only consider the current allegation but also whether the alleged perpetrator has access to other children.
- If there is credible justification to determine that the historical sexual abuse occurred, then steps should be taken to conduct safety evaluations on any children with whom the perpetrator could have had inappropriate contact. These tasks should be coordinated with MPD whenever possible.

SAFETY EVALUATIONS: INTRA-FAMILIAL CHILD SEXUAL ASSAULT

Scope

Intra-familial child sexual assault evaluations occur in matters involving a perpetrator fitting the definition of an intra-familial relationship (see *Overview* section above) but the perpetrator **IS NOT** a parent or caregiver acting *in loco parentis*. These evaluations encompass allegations that occur in the District of Columbia, regardless of the location of the child's primary residence.

Reminder: the perpetrator in these matters may be a minor or an adult.

Note: In order for a minor to be considered a perpetrator, there must be a *four-year age* difference between the perpetrator and victim, except in cases of forcible sex, in which case there is no required age difference. In the situations where the alleged perpetrator is a minor, there are no allegations per se to be investigated by CPS. You must still evaluate, however, the safety and well-being of the child. If concerns develop during the course of the evaluation regarding any failure to protect or other maltreatment by a caregiver or caregiver acting *in loco parentis*, the evaluation must be converted to an investigation and the appropriate allegations added to FACES.

- For reports of a “**child on child**” sexual assault, the social worker shall evaluate the family of origin of the alleged perpetrating child and assess whether the perpetrating child has suffered sexual abuse. In addition, the social worker shall assess whether there are any other children at risk of being exposed to the perpetrating child.
- In such matters, the alleged victim child is assessed as a collateral source of information to the evaluation.
- You and your management team will have the discretion to decide whether the situation warrants further intervention, or whether to enter a companion evaluation/investigation of the victim child's family of origin.

Evaluation Lead

As a general rule, the assigned YID detective takes the lead for evaluating sexual assault allegations involving children. There is, however, a standing agreement that an immediate joint evaluation shall occur when a report includes information that an alleged perpetrator lives in the same home of the alleged victim, or has regular access to the child victim, and/or there is obvious or imminent danger to the child. In such instances, you should communicate as soon as possible with YID to begin the joint investigation as appropriate.

Reminder: alleged perpetrators may also be minors who live in the same home *and may pose an equal level of danger*. If information about unsafe access between a perpetrator and a child is discovered during the evaluation, this should be discussed with your management team and forwarded to YID for intervention.

It is important for you to remember that response times for YID evaluations and CFSA evaluations do not always coincide. As a result, it may be challenging in some instances for your evaluation to begin without an assigned detective.

NOTE: When you are not able to conduct a joint evaluation due to a detective not being assigned, you should not directly discuss the allegations with the caregivers or child (ren). Doing so may compromise a future police investigation by prematurely disclosing sensitive information. Ideally, the child (ren) should be interviewed at school or other neutral environment. If the children cannot be interviewed in a neutral environment and must be interviewed at home, the specific allegations should not be directly discussed with the caregiver but you should explain that the Agency has received a complaint regarding the safety and well-being of the child (ren) and you need to assess the safety and well-being of the family. The interview of the child (ren) should follow the components discussed in the *general child interview*, including a [preventive assessment for sexual abuse](#). If the child makes a disclosure during this interview, the police should be contacted to determine what, if any, immediate role they may need to play.

Special Note: care should always be taken to minimize trauma by limiting the number of times a child needs to be interviewed.

MPD may at times determine that the reported allegation does not meet their standard for an evaluation. In those situations, you will be the lead and sole evaluator of the TOT'd allegations. If, however, additional details or allegations are discovered during the CPS evaluation, and you determine there is a need for a criminal investigation, you should consult with your management team and forward the information to MPD for assessment.

Conversation with Non-offending Caregiver

When a child has been sexually assaulted, there may still be a non-offending and/or protecting caregiver involved. You must take care to thoroughly assess the situation and, if necessary, to follow through on needed services for the child. Safety planning is also a crucial component for maintaining stability for a child victim in these situations. *You should consider the following factors when assessing the caregiver's ability to protect the child both physically and emotionally:*

- Attitude of the caregiver toward the victim child and perpetrator
- Willingness of the caregiver to ensure that the perpetrator does not have access to the child, including obtaining a protective order
- Willingness of the caregiver to participate in ongoing services for the child, including the CAC interview, medical examination, and therapeutic services

When discussing the evaluation with a non-offending caregiver, care should be taken to instruct this individual on appropriate interaction with the child:

- The caregiver should not unduly discuss the evaluation with the child.

- The alleged perpetrator should not be informed of the evaluation or any pending investigation, nor should the caregiver confront the alleged perpetrator about the allegations.

Safety Planning after Sexual Abuse Allegations

- **Safety plans** should be detailed and written.
- They must be signed by the social worker, caregiver, and supervisor.
- Under no circumstance should CPS personnel be party to a safety plan that does not include **removal of the offender from the family home**.
- When the offender is an adult, the safety plan must include a strategy to prevent the offender from having access to the victim(s).
- When the offending child is a minor and a lack of resources prevents the family from planning for separate living situations for the perpetrator and victim, a very specific and careful safety planning must occur.
- The **preferred** safety plan involves both discontinued contact and separate living situations for the perpetrating youth and victim.

**REMEMBER! YOU ARE REQUIRED TO MONITOR SAFETY PLANS
UNTIL SUCH TIME THAT THE CASE IS TRANSFERRED.**

Medical Examination

Please see the discussion regarding medical examinations above under the Sexual Abuse Investigations section and follow the guidelines outlined there.

Special Note: *a child should never be transported for a medical examination by the alleged perpetrator of sexual abuse.*

CAC Interview

Please see the discussion regarding medical examinations above under the Sexual Abuse Investigations section and follow the guidelines outlined there.

Historical Allegations

CFSA does not have a statute of limitations for reports of sexual abuse. There are, however, such limitations within the criminal system. The CFSA social worker needs to be prepared in such instances to investigate historical situations without police assistance.

- When considering historical allegations, you must consider current circumstances, including whether the alleged perpetrator has access to other children.
- If there is credible evidence for determining that the historical sexual abuse occurred, then steps should be taken to conduct safety evaluations on any children with whom the perpetrator could have had inappropriate contact. These tasks should be coordinated with MPD whenever possible.

When evaluating historical allegations that do not involve a caregiver acting *in loco parentis*, you should carefully consider what purpose CPS involvement will serve, particularly when the Agency will have no authority to substantiate an allegation, even if it is true.

Factors for Consideration:

- Where does the family currently reside?
If the family resides outside of the District, consider a referral to the CPS unit of the appropriate jurisdiction. In such situations, the evaluation will be closed with CFSA although further MPD investigation may occur.
- Does any child need supportive services?
If the child is stable and there are no other safety factors, an evaluation from CPS may not be warranted.
- Does the perpetrator have access to the victim?
If the perpetrator does not have access to the victim and there are no other safety factors, an evaluation may not be warranted.
- If the perpetrator was a minor at the time of the offense, is the perpetrator still a minor?
If the perpetrator is now an adult and there are no other safety factors, an evaluation may not be warranted.

FACES Core Contacts and Assessments

Because there are no allegations in safety evaluations, the standard medical and educational core contacts are not required. The non-offending caregiver is expected to be appropriately caring for the child, including being aware of the child's medical and educational needs. The family's privacy will not be invaded further by investigating these areas. If there is cause to suspect a problem, you should follow-up on a case-by-case basis as needed with the child's medical and educational providers to ensure the child's safety and well-being. The safety assessment shall be completed for all safety evaluations. The risk assessment is not required as it involves investigation of the non-offending caregiver.

An example of such a scenario is:

A 10 year old female lives with her biological parents. The mother's brother is in town visiting and provided child care for the 10 year old on one occasion while the parents went to the movies. The uncle has no prior sexual abuse history and there were no indicators to suggest that he is an inappropriate caregiver for children. However, during this child care situation, the uncle fondled the 10 year old and told the child that if she disclosed he would do the same thing to her 5 year old sister.

When the parents returned home, the 10 year old was able to speak to her parents privately and disclosed what happened. The parents responded by believing the child, calling the police, and ensuring that the uncle did not have access to the children until the police arrived.

In this scenario, the parents are not under investigation. CPS is only involved as it relates to ensuring the safety and wellbeing of the children. This is done in teamwork with the parents. Collateral contacts with primary medical doctors, educators, and so forth for the family children will not be completed as there is no reason to suspect concerns in these areas. However, if school personnel or medical providers may have knowledge of the sexual assault allegations they should still be contacted.

SAFETY EVALUATIONS: CHILD SEXUAL ACTIVITY

Scope

As noted in the *Overview* of this section, reports of **child sexual activity** include behaviors, statements, or other indications of developmentally inappropriate sexual knowledge suggestive of potential child sexual abuse. If more than one child is involved, such activity must have occurred between children with less than a four-year age difference (unless force is involved).

Evaluations of such matters do not require an intra-familial relationship between the children, nor do the children involved need to live in the District. If the report alleges that the child sexual activity occurred in the District, CFSA will evaluate for the safety and well-being of the child. If concerns develop during the course of the evaluation regarding any failure to protect or any other maltreatment by a caregiver acting in *loco parentis*, the evaluation must be converted to an investigation and the appropriate allegations added to FACES.

- ◆ When working with a “**child on child**” sexual assault evaluation, a primary evaluation is taken regarding the family of origin of the alleged perpetrating child (if one can be determined). It is your responsibility to carefully assess whether the perpetrating child has suffered sexual abuse and/or whether there are any children at risk for being exposed to the perpetrating child.
- ◆ Under such circumstances, the alleged victim child is assessed as a collateral source of information to the evaluation.
- ◆ Both you and your management team have the discretion to determine whether the situation warrants further intervention, and/or whether to enter a companion evaluation or investigation regarding the victim child’s family of origin.

Evaluation Lead

As a general rule, the MPD Youth Investigations Division detective who is assigned to a sexual abuse evaluation also takes the lead in assessing the reported child sexual activity.

- As discussed earlier, there is a standing agreement between CFSA and MPD that if an alleged perpetrator lives in the home with an alleged victim, or has regular access to the child, that they will immediately conduct joint evaluations, particularly if there is immediate or potential danger to the child.
- Upon assignment of an evaluation related to child sexual activity, you should determine if there is immediate danger to the child and/or whether it is necessary to contact YID for a joint evaluation.
- **Reminder:** alleged perpetrators may also be minors who live in the same home and may pose an equal level of danger.
- Since the response times for CPS evaluations and MPD evaluations do not always coincide, it may be challenging to begin a child sexual activity evaluation without an assigned detective.
- When you are not able to conduct a joint evaluation because a detective has not been assigned, you should avoid direct discussion about the allegations with the caregivers or child (ren). *Doing so may compromise a future police investigation by prematurely disclosing sensitive information.*
- Ideally, the child (ren) should be interviewed at school or at any other neutral environment. **Special note:** if the children cannot be interviewed in a neutral environment and must be interviewed at home,

the specific allegations should not be immediately discussed with the caregiver. Explain simply that the Agency has received a complaint regarding the safety and well-being of the child (ren) and you are obliged to assess the safety and well-being of the family in general.

- The interview of the child (ren) should follow the components discussed on in the *general child interview*, including a preventive assessment for sexual abuse.
- If the child makes a disclosure during this interview, the police should be contacted to determine what, if any, immediate role they may need to play.
- If information about unsafe access between a perpetrator and a child is discovered during the evaluation, this should be discussed with your management team and forwarded to YID for intervention.

MPD may at times determine that the reported allegation does not meet their standard for an investigation. Under these circumstances, you are considered the lead and sole evaluator of the TOT'd allegations. If, however, during the evaluation additional details or allegations are discovered that may suggest the need for a criminal investigation, these should be discussed with your management team and forwarded to MPD for assessment.

Medical Examination

A forensic medical examination is not required in child sexual activity evaluations but is recommended. You should ensure that the caregiver for each child is given information on CAPC and you should recommend that the child have a medical examination. Since there are no direct allegations of sexual abuse during a child sexual activity evaluation, you may not necessarily be able to require a caregiver to comply with the request for a medical examination.

CAC Interview

As noted above, there are no direct allegations of sexual abuse during a child sexual activity evaluation. Therefore a CAC interview may not be required in every instance. Nevertheless, the CAC will participate in “precautionary” interviews of children in this category if a detective is assigned. Unless there are specific reasons why a CAC interview is not necessary, the CPS worker should arrange for a CAC interview for child sexual activity evaluations. If there is a determination that a forensic interview is not necessary this should be discussed with your management team and the assigned detective (if applicable).

Historical Allegations

When evaluating historical child sexual activity allegations, the CFSA social worker should carefully consider what purpose CPS involvement will serve, particularly when there is no formal allegation and the Agency will have no authority to substantiate an allegation, even if it is true.

Factors for Consideration:

- Where does the family currently reside?
If the family resides outside of the District, consider a referral to the CPS unit in the appropriate jurisdiction.

In such instances, the evaluation will be closed with CFSA although further MPD investigation may occur.

- Does any child need supportive services?

If the child is stable and there are no other safety factors, an evaluation from CPS may not be warranted.

FACES Core Contacts and Assessments

Because there are no allegations involved with safety evaluations, the standard medical and educational core contacts are not required. The non-offending parent or caregiver is expected to be appropriately care for the child, including being aware of the child's medical and educational needs. The family's privacy will not be invaded further by investigating these areas. If there is cause to suspect a problem, the social worker should follow-up on a case-by-case basis as needed with the child's medical and educational providers to ensure the child's safety and well-being. The safety assessment shall be completed for all safety evaluations. The risk assessment is not required as it involves investigation of the non-offending caregiver.

SAFETY EVALUATIONS: SUGGESTED SEXUAL ABUSE

Scope

As a CPS social worker, you are responsible for conducting evaluations **even when circumstances are only suggestive of sexual abuse that may have occurred or potentially will occur**. Children living under the following situations may be victims of sexual abuse and/or vulnerable to potential sexual abuse:

- Exposure to adult sexuality (for the sexual gratification of the perpetrator)
- Residing with a sexual offender
- Sexual exploitation of the child (pornography, prostitution, etc.)
- Other risk factors related to sexual abuse

Reports on any of the above situations may be accepted on a case-by-case basis and should be discussed amongst the CPS management prior to acceptance for evaluation.

Note: Allegations that a child is exposed to sexual activity (live or simulated) by a caregiver are only taken as sexual abuse safety evaluations IF the alleged perpetrator was intentionally exposing the child for their own sexual gratification. All other matters may be investigated as general neglect and are handled by traditional units.

Evaluation Lead

If there is a YID detective assigned to a report that fits the above criterion, the detective will maintain lead responsibility for the evaluation or, if warranted, investigation. In many instances, such matters are initially evaluated by CPS alone.

Medical Examination

A medical examination should occur when there is credible reason to believe that a child has been sexually abused or assaulted. Even in instances such as exposure to pornography or a child displaying risk factors related to sexual abuse, a medical examination should still be recommended to the caregiver, even if there is no direct information of sexual abuse or sexual assault. If there are any questions with regard to whether a medical examination is warranted based on the evaluation of this criterion, you should consult with your management team.

Special Note: *a child should never be transported for a medical examination by the alleged perpetrator of sexual abuse.*

CAC Interview

When there are no direct allegations of sexual abuse or sexual assault, a CAC interview may not be required in every instance where there is a concern for possible or potential abuse. Nevertheless, the CAC will participate in “precautionary” interviews of children in this category when a detective is assigned. Unless there are specific reasons why a CAC interview is not necessary, you should plan to arrange for a CAC interview when evaluating possible sexual abuse reports. If there is a determination that a forensic interview is not necessary, but there are other concerns, these should be discussed with your management team and the assigned detective (if applicable).

Historical Allegations

Historical concerns of possible child sexual abuse or sexual assault shall be handled on a case-by-case basis and assessed by CPS management, prior to assignment for evaluation.

FACES Core Contacts and Assessments

Because there are no allegations associated with safety evaluations, the standard medical and educational core contacts are not required. The non-offending parent or caregiver is expected to be an appropriate caregiver for the child, including being aware of the child’s medical and educational needs. The family privacy will not be invaded further by investigating these areas.

If there is any cause to suspect a problem, you should follow-up on a case-by-case basis as needed with a child’s medical and educational providers to ensure the child’s safety and well-being.

The safety assessment shall be completed for all safety evaluations. The risk assessment is not required as it involves investigation of the non-offending caregiver.



INSTITUTIONAL INVESTIGATIONS

Abuse and neglect are traumatizing to children at all times but when it happens to a child who has been placed in out-of-home care, it is an egregious violation that deserves serious attention. All Hotline reports that allege abuse or neglect at facilities that are licensed or certified by the District of Columbia are “institutional abuse” referrals and will be investigated by CFSA's Institutional Investigations unit.

When investigating institutional abuse, you will conduct the investigation in one or more of the following settings:

- Emergency care facilities
- Licensed or temporarily-licensed resource homes in the District
- Independent living programs
- Runaway shelters
- Youth group homes
- Youth shelters
- Any other out-of-home facility that provides custodial care, including daycare centers, before and after-care programs, hospitals, residential facilities, acute psychiatric care facilities, and/or all other licensed facilities that provide direct care and/or supervision of children and youth

REMEMBER: institutional abuse includes physical or mental injury, sexual abuse or exploitation, negligent or maltreatment of a child by any individual at the facility or resource home who is responsible for a child's out-of-home care, including one or more of the following providers:

- The child's foster parent
- An employee or staff person of a public or private residential home or facility
- Other persons legally responsible for the child's welfare in a residential setting
- Any CFSA staff person providing out-of-home care

General Guidelines

An investigation of institutional abuse requires the same cooperation, teaming, and sharing of accessible information as that which occurs between CPS and all other CFSA administrations during any other investigation, including but not limited to teaming with contracted-agency staff and CFSA staff responsible for licensing, monitoring, placement, and program operations.

Whenever a Hotline report meets any of the following criteria, the institutional investigation must be initiated **immediately**:

- A child is left alone.
- A child is left with inadequate supervision.
- A child is in immediate danger.
- Priority Level I report (*see Procedure F: Priority Criteria of Hotline Policy*). **Note:** for all Priority I reports, the CPS institutional investigator must contact the Metropolitan Police Department's Youth Investigations Division (YID) to coordinate a joint investigation.

When you receive an assignment to investigate an institutional abuse report, you must **immediately** notify the CFSA staff member responsible for monitoring the private agency, or licensing the facility 144

(including youth shelters, runaway shelters, emergency care facilities, and youth group homes). You must team and coordinate the investigation (to the best of your ability) with that assigned monitor or licensing specialist. **Note:** *If the facility is not licensed by CFSA, you should contact and notify the appropriate licensing agency of the report and concerns related to the safety of children in placement. When appropriate and practical, you can arrange a joint investigation.*

REMINDER: *if any report of abuse or neglect is identified as having a Priority Level I response, you may proceed independently of the monitor or licensing specialist (if they are unavailable) but **you must contact YID.***

Procedures

- When investigating foster homes, notify the Contract Monitoring and Performance Improvement Administration (CMPIA) and inform the appropriate monitor of the investigation, sharing all necessary information, and jointly coordinating the investigation. If the monitor is unavailable for a joint investigation, you must inform the assigned supervisor and request follow-up from the monitor within 24 hours.
- When investigating facilities, notify the Facilities Licensing Unit in the Office of Planning, Policy, and Program Support and follow the same procedures as #1 above. The licensing specialist, if unavailable, must confer with you within 24 hours.
- For all Priority I investigations that were not held jointly, you must schedule and convene a meeting within 48 hours of the investigation to share information with either CMPIA staff or the Facilities Licensing Unit.
- If there are no removals during investigations of institutional abuse, the assigned monitor or licensing specialist shall make weekly visits to the home or facility where allegations are reported.
- During the course of the investigation, as the institutional investigative social worker, you should continually team with the monitor or licensing specialist to review case notes, interviews, and other records to jointly assess the information.
- When you have made your disposition decision after investigating a facility, the licensing specialist will have 5 days to issue a separate report with recommendations for any proposed licensing actions.

SPECIAL NOTE: *during an investigation, the resource home or facility will be placed on hold for receipt of any additional children.*

Removals

If you have been unable to jointly investigate an institutional abuse report, **and** you have decided to remove a child or youth from the home or facility, you must notify the assigned monitor or licensing specialist of the removal, and the basis for the decision as well as any additional concerns regarding the safety and well being of the other children placed with the provider. *When applicable, the monitor or licensing specialist shall be involved in the development of a safety plan.*

If the child(ren) are removed from a foster home, the ongoing social worker must notify the resource parents of their right to a fair hearing. Notification may be oral or in writing and take place within 24 hours of the emergency removal. Prior to an adjudication of neglect, non-emergency removals can not take place until there has been at least 48 hours of notice. After an adjudication of neglect, non-emergency removals can not take place prior to 10 days of notice and if the foster parent requests a Fair Hearing, the removal may not take place until after the Fair Hearing.

Written Reports of Institutional Investigation Findings

- You must complete a written report within 30 days detailing the investigation findings.
- Notification of Disposition and Fair hearings must be sent to the alleged perpetrator(s) within seven (7) calendar days (*see CFSA Fair Hearings Policy*).
- The monitor or licensing specialist shall discuss the investigation findings with the foster parent(s) or facility administrator, as appropriate, within 5 business days of the notification of the investigation findings.
- You should send a copy of the written report with the disposition to the ongoing social worker and the child-placing agency or facility administrator.
- The ongoing worker will be responsible for notifying the caregiver and the guardian ad litem, including where the incident occurred and those who were involved.
- If any licensing action was taken, the licensing specialist will be responsible for forwarding this information to the ongoing worker, the caregiver, and the guardian ad litem.

Disposition Staffings

Disposition staffings are convened at the end of the institutional investigation in order to share the findings of the investigation and discuss any lingering concerns regarding the child who was the subject of the report or any other children placed within that placement resource. The staffing provides a forum for shared decision-making and serves as a vehicle for developing a corrective and/or safety plan.

When the facility or resource home is licensed by CFSA, a disposition staffing will be held within thirty (30) days of acceptance of the report in order to review the findings of the investigation. The Institutional Investigations supervisor is responsible for chairing the disposition staffing and notifying the following individuals of the staffing date and location:

- Institutional Investigations worker
- Licensing specialist
- Monitor
- CFSA General Counsel and/or OAG attorney or their designee(s), if appropriate
- On-going supervisor
- On-going social worker

Attendees at the disposition staffing will participate in the following activities:

- a. Discuss the results of the investigation.
- b. Review the child(ren)'s current placement(s) and determine whether any change in placement is required to protect the child(ren)'s safety and health.
- c. Review the contract status and identify any additional steps to be taken to protect the child or other children placed in the same setting.

- d. Discuss the facility's compliance with applicable District of Columbia Municipal Regulations.
- e. Determine whether and when to take action concerning the license or the contract.

POPULATION SPECIFIC INVESTIGATION CONSIDERATIONS

ASSESSING CHILDREN AGES 0-3

Infants and very young children (ages 0-3) are at the highest risk for life-long emotional, mental, and physical problems when they are victims of abuse or neglect, homelessness, domestic violence, and/or prenatal exposure to drugs or alcohol. Given their high vulnerability, it is imperative that you conduct a thorough assessment of their safety and well-being. As a required practice, comprehensive assessments must take place, and must include direct observation of the child. You should take a close look at their medical history as well as any other additional needs.

CFSA's Administrative Issuance, *CFSA-05-5Referral of Supported Child Abuse/Neglect Cases to the Early Care and Education Administration*, offers the following guidance:

- Refer each child (who is under 3 years of age and residing in the household) for a 0-3 screening within 72 hours of a substantiated investigation.
- Complete the **0-3 Early Intervention Screening Referral Form** and manually forward the form to OCP with a hard copy maintained in the child's case record.

The following steps will guide your assessments of safety and risk for children 0-3 and help you to determine appropriate interventions and service needs:

- Gather the child's birth information.
- Caregivers Information
 - Assess the role of the mother/other female adults relating to the child.
 - Determine if mother received prenatal care and whether the child was exposed to drugs, alcohol or medication during pregnancy. (Seek a substance abuse consult if the mother has used or you suspect she continues to use drugs or alcohol. Assess the role of the father/other male adults relating to the child.
- Assess the caregiver capacity to care for the infant.
- Gather information about the child's general care and development:
 - Primary caregiver
 - Size & development
 - Feeding
 - Sleeping arrangements (Inform the caregiver that "co-sleeping" with the baby is very dangerous and that a baby can be hurt or suffocated if an adult rolls over the child.)
Remember: Babies must sleep on their **backs** on a firm mattress without pillows or stuffed toys or blankets near the babies face! (Please see the section that follows on *The Dangers of Co-sleeping*.)
 - Child care/supports

Special Considerations in Interviewing an Infant	What to look for when Providing a Quality Assessment of an Infant
<ol style="list-style-type: none"> 1. The infant must be observed AWAKE, without any external distractions. It is NEVER sufficient to observe a sleeping infant. 2. Developmental Milestones <ul style="list-style-type: none"> • Is the infant on target with his/her developmental milestones? 3. Physical Appearance <ol style="list-style-type: none"> a. Physical condition of the baby: skin, eyes, etc. b. Breathing: does it appear normal or labored? c. Is the infant average in size for his/her age? d. Does the baby move all four limbs? e. How alert is the baby? f. Any obvious disabilities? g. How does the baby smell? h. Are his/her clothes clean? i. Is the sleeping area clean and safe? j. Does the baby have a crib? 4. Interaction between infant, caregiver(s), and others in the home <ul style="list-style-type: none"> • Do they respond to the babies interactions? How? • How does the baby respond to the caregiver? • Do the caregiver and baby look at each other? • Does the baby appear comforted when the caregiver picks him/her up? • Do the caregiver/others make positive statements about the baby? • Does the caregiver smile when talking about the baby? • Does the baby cry, smile or laugh? • How does the caregiver respond to the cries? • Can the caregiver differentiate between the types of cries and recognize what each cry expresses? • Does the baby react to toys and other objects? • Is he/she socially responsive? • Does the baby have a regular eating and sleeping schedule? 	<p>Early Intervention Red Flags for Children 0-3:</p> <ol style="list-style-type: none"> 1. Physical <ul style="list-style-type: none"> • Child does not use both sides of body equally or favors one side • Child is awkward and trips a lot • Child 12 months and older seems unable to hold onto things • Child 18 months and older is not walking confidently 2. Speech <ul style="list-style-type: none"> • By 7 months, no signs of cooing or babbling • By 12 months, doesn't have a few single words • By 2 years, not verbalizing “dat” or pointing to what he/she wants • By 2 years, doesn't have any short sentences or word combinations • By 2 years, can say word, but doesn't use them to talk to people 3. Adaptive <ul style="list-style-type: none"> • Difficulty eating: Losing fluid when sucking, gagging, refusing certain textures • Difficulty sleeping (excessive sleeping, lethargy, night terrors, rigidity, tenseness) • Extreme sensitivity to certain experiences, like bathing, dressing (sensory integration problems) 4. Cognitive <ul style="list-style-type: none"> • By 6 months, does not shake, bang, drop, and/or mouth objects • By 9 months, does not turn when name is called or to locate a sound • By 12 months, does not containerize or put 2 things together • By 24 months, does not use 2 word phrases • By 24-30 months, no simple pretend play • By 30 months, not able to match shapes: circle, triangle, etc. • By 36 months, not able to feed him/her self 5. Social/Emotional <ul style="list-style-type: none"> • Cannot be consoled • Does not make eye contact

	<ul style="list-style-type: none"> • Appears expressionless, or is inappropriately friendly • Injures self (scratching/biting/head banging)
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The Dangers of Co-sleeping



Co-sleeping with an infant is very dangerous! It puts the infant at high risk of accidental death due to suffocation. This may happen when caregivers accidentally roll over onto their infant or the infants suffocate in the bedding or pillows. We understand that caregivers may want to keep their babies close to them at night to make it easier for them to access their infants quickly for night feedings. We also know that some caregivers may not have a separate bassinet or crib for their infant. Even still, we strongly recommend that caregivers NEVER sleep in the same beds as their baby!

The American Academy of pediatrics does not recommend co-sleeping with an infant in the first year of life.

As an alternative, caregivers may place the infant in a traditional bassinet or portable crib that is placed right next to the caregiver's bed. This way, the baby is in a safe sleeping place yet close enough for bonding and monitoring. For those families who do not have a safe sleeping space for their baby, please consult with your management team for guidance.

NOTE: Given the number of infant related fatalities as a result of co-sleeping this point cannot be emphasized enough!

ASSESSING CHILDREN WITH KNOWN/POTENTIAL EXCEPTIONAL NEEDS

Child Development and Special Service Needs

As a CPS social worker, you **MUST** understand child development milestones in order to recognize what may be missing in the development of the children during your assessments. You are not expected to conclude that a child's developmental lag is serious but you must recognize when the child needs further evaluation or specialized treatment.

Assessing Children with Exceptional Needs

Children with exceptional needs include those with physical, emotional and/or mental disabilities. Some of these disabilities may present as physical or mental delays, blindness, hearing impairments, mobility challenges, dependency, behavior management problems, emotional difficulties, etc. Children with exceptional needs are also **vulnerable children**, more so than a wholly healthy child. Specifically, **child vulnerability** refers to a child's capacity for self-protection. If the child has a diagnosis or condition, you must describe it in detail in your notes.

Children with Exceptional Needs: Special Areas of Consideration
Communication- How does the child best communicate? Verbally? Visually? Through a communication board? Drawing? Frequently, receptive skills are higher than expressive skills, therefore it is important speak with someone who knows the child's skill levels.
Mobility- What are the child's mobility capabilities? Can the child get around on his or her own? What is the level of freedom of movement?
Dependency- Is the child solely dependent on the care of someone else? Lifelong dependency may cause a child to be trusting and less likely to question care or requests. The child may have become accustomed to others providing personal care, therapy or some other type of assistance and being in a position of authority. As a result, the child may confuse exploitation with appropriate care.
Compliance- Children who require specialized care or supervision are sometimes rewarded for being compliant. Assertiveness or self-advocacy may not be encouraged. Be aware that sexual interest and development for children in the mild and moderate ranges of developmental disabilities occurs at about the same time it occurs in typical peers. Lack of skills in protecting oneself from sexual abuse may place the child at risk.
Cognition- Sometimes it may be difficult for a child to identify or understand a situation in a way that represents what actually happened. The challenge may involve process or language, or the child may not understand the nature of the situation (e.g., a child requiring personal care may have difficulty identifying exploitive touch).
Isolation- The circle of friends and outside acquaintances may be limited and activity-driven, thus limiting the opportunity for the child to have people in whom to confide. If a child has been the victim of someone who is familiar, there may be fear of retaliation. If the child has few contacts, even the loss of someone who may have harmed him/her can be frightening.
Behavior Control- Behavior is a means of communication. Some behavior controls are psychotropic medication, isolation from others, or the use of other types of restraints. If there are concerns or doubts

about behavioral controls, please consult your supervisor.

Credibility- There may be times when some of the indicators of abuse are overlooked because they overlap with the child's disability. For example, a child may be on medication that impacts their affect, resulting in communication challenges that may inadvertently "cover up" an indicator.

Engaging Caregivers who have Developmental Delays



As a CPS social worker, you may receive a referral for a caregiver who has developmental disabilities. Do not be misguided into thinking or assuming that people with cognitive disabilities cannot be adequate parents. This is not the case. Research studies indicate that most parents with cognitive disabilities have unique combinations of strengths and support needs but they still establish loving bonds with their children. It is important to realize that parents with cognitive disabilities share many common problems:

- The day-to-day demands of care giving are a common challenge for the parent with disabilities.
- Parents with cognitive disabilities tend to have some difficulty retaining and correctly applying the information and skills needed for adequate parenting.
- Many lack social and play skills and have difficulty with managing money.
- For parents who have difficulty in communication and social relationships, the effect is seen not only in the parent-child relationships but also in the family's ability to relate to others within the community, including the service systems that become involved in their lives.

You must be sure to continue to use your core helping skills and maintain your objectivity when assessing these types of families and the children in the home. Conduct your investigation as you would with other families. The practice guidance below will help you interview caregivers/parents with learning disabilities:

- Keep interviews as short as possible. Take a break if the caregiver/parent seems to be losing concentration.
- Keep your questions simple and be prepared to probe the responses given.
- Avoid close-ended questions (e.g., ask the parent to describe a situation versus asking the parent a "yes" or "no" question). **Note:** many people with a learning disability are eager to please, so be careful not to prompt them with a suggestion or they may agree with what you have said.
- Be very patient with the process and allow time for repetition.

The D.C. Department of Disability Services (DDS) can help with the coordination of all services and supports provided to all qualified persons with intellectual disabilities in the District of Columbia. **Please see the appendix for the DDS intake application.**

You can refer any of the following clients for services:

- Any individual who has a diagnosis of mental retardation.
- Any individual who has a diagnosis of Down syndrome.

- Individuals who are dually diagnosed (mental retardation and mental illness).

DIPLOMATIC IMMUNITY INVESTIGATIONS

Required Task	Assess/Describe/Document
Determine if Diplomatic Immunity is a potential concern.	<p>*Obtain information from the alleged perpetrator or caregiver regarding their position, embassy affiliation, and immunity status.</p> <p>*DO NOT move forward with the investigation after obtaining the above information (even if MPD is proceeding).</p>
Immediately notify the Office of the General Counsel (OGC).	<p>*Provide all information obtained.</p> <p>*Provide all demographic information.</p>
OGC to Contact State Department.	<p>*OGC will contact the State Department to determine the level of immunity.</p> <p>*The level of immunity will then determine the extent of the investigation.</p>

Conduct Investigation.	*SW will conduct investigation per the directive of OGC.
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MILITARY INVESTIGATIONS

Required Task	Assess/Describe/Document
Determine if investigation involves an active duty military person.	<p>*Obtain information from the family regarding military status, branch of the military and base assignment.</p> <p>*Please note that Active Duty Military may reside on-base or off-base.</p>
<p>You should immediately contact the support centers listed below when a report is received regarding child maltreatment.</p> <p>Notification should also be made to the Provost Marshall and/or Military Police associated with that particular branch of the military.</p> <p>If you are unable to determine which branch to contact, contact the Walter Reed Family Advocacy Center, which will determine the point of contact.</p> <p>ARMY</p> <p>Walter Reed Family Advocacy Center</p> <p>Department of Social Work – Commander Tracy Jackson-Weaver 202-782-6378/Captain Janet Vaughn (as of 5/1)</p> <p>Program Manager – Shay Tull-Cook (acting) 202-782-</p>	<p>*Provide all information obtained.</p> <p>*Provide a copy of the Hotline report to the program manager.</p> <p>*Coordinate services with the program manager and/or social workers from Family Advocacy as well as base personnel.</p>

<p>0454</p> <p>Provost Marshall/MP – 202-782-4190</p> <p>AIRFORCE</p> <p>Family Advocacy Bolling Air force Base</p> <p>Karen Jay 202-767-0611</p> <p>NAVY</p> <p>Anacostia Fleet and Family Support</p> <p>202-433-6151</p> <p>MARINES</p> <p>Henderson Hall Family Advocacy Program</p> <p>703-614-7204</p> <p>COAST GUARD (now under Homeland Security)</p> <p>Family Advocacy Program</p> <p>Program Manager – Dr. Laurel Shuster CG-1112 202-475-5157</p> <p>Notify the Walter Reed Army Medical Center (WRAMC) Family Advocacy Center</p> <p>202-782-0453</p>	
<p>Conduct a Joint Investigation.</p>	<p>*SW will conduct investigation, provide child protective services, and provide medical treatment in a joint and collaborative manner with the WRAMC and YID.</p>

Provide recommendations to Family Advocacy.	*Provide a copy of the investigation summary and recommendations to the Family Advocacy Center so that the military can provide services to the family.

INDIAN CHILD WELFARE ACT

Any time we receive reports involving persons who consider themselves members of any recognized tribe, CPS is mandated to report to the Bureau of Indian Affairs who will then coordinate with the tribe.

<http://narf.org/icwa/index.htm> has a guide to the Indian Child Welfare Act

We are to file reports with:

Department of the Interior

Bureau of Indian Affairs

Contact is Sue Settles, Social Services 202-513-7621

SPECIAL INTEREST INVESTIGATIONS



Special Interest Investigations involve an individual of “special interest”. These individuals include, but are not limited to, elected or appointed officials (including judges), officers of the Metropolitan Police Department (including officers in the Youth Division), and/or employees of CFSA. As with all CPS investigations, confidentiality is paramount.

- Only CFSA’s CPS Administration can conduct this type of investigation.
- FACES access to all information related to the investigation is restricted. Only the identified CPS staff will have access to the investigation.
- Typically these investigations are handled by the CPS Special Abuse Unit or the CPS Institutional Investigations Unit.
- If you discover during your investigation that you have an investigation involving a person of “special interest” you must immediately notify your management team and await further instruction.
- Specifically, if you have an investigation involving an MPD officer you must immediately confer with your management team and also with MPD YID.
- Contact the CFSA General Counsel.

DECISION MAKING AND PLANNING

GENERAL CONSIDERATIONS FOR ASSESSING SAFETY & RISK

SAFETY VERSUS RISK	
SAFETY	RISK
Safety deals with present or imminent danger.	Risk is the likelihood that a child may be abused or maltreated in the future.
Safety factors pose a threat of immediate or imminent harm.	Risk elements identify significant behaviors and circumstances within a family unit that create different levels of risk to the child.
Safety factors pose a threat of serious harm.	Risk may be very high even if the report is unfounded; conversely, risk may be low even if the report is substantiated.
In order to control for safety , there must be an assessment of the need for immediate interventions, the vulnerabilities of the child(ren), as well as strengths, resources or protective capacities present in the family.	Risk may be reduced with appropriate services, changes in the caregiver's behavior, and family/community support.

To support the Agency's goal of safety, permanency and well-being for children and their families, two assessments are completed during the course of every CPS investigation: (1) **SAFETY** and (2) **RISK**.

SAFETY, which deals with present or imminent danger, is assessed every time you interact with a child or family throughout the investigation. The safety assessment process is documented in FACES and will be detailed in your contacts and/or assessment notes.

RISK is the likelihood that a child may be abused or maltreated in the future. The Structured Decision Making (SDM) risk assessment tool assesses families for low, moderate, high, or intensive probabilities of future abuse and/or neglect. These risk levels, along your clinical judgment, guide the decision whether or not to open a case, whether to refer the family to a collaborative, or whether to close an investigation with no further services.

THE SAFETY ASSESSMENT

You are required to complete the safety assessment at the onset of an investigation in order to determine the immediate threat or danger of harm to the child. In addition to the signs of present danger, the safety assessment will identify the caregiver's protective capacities and the child vulnerabilities. **The initial Safety Assessment must be completed within 24 hours of the time of intake at hotline.** Please reference the documentation section for additional details on completing this assessment in FACES.

Remember:

- Safety decisions must be made for each child participating in the household.

- Decisions may differ for each child depending on the allegations and circumstances.
- A safety decision should be completed within 24 hours of the report ***EVEN*** if no contact has been established.
- Keep in mind that you can submit a referral to the Healthy Families Thriving Communities Collaborative (HFTCC) referrals at any point during the course of the investigation. These referrals can be made regardless of whether the allegations are Unfounded or Substantiated. ***Note: The HFTCC are now accepting referrals in which the allegations are unfounded yet the SDM Level is high or intensive.***

Note: The **provision** of **services** or other assistance to the child's family takes place throughout all child welfare intervention, including CPS. Please do not delay any needed referrals for services or support to the family to the HFTCC or other government agencies or community based service providers.

Safety is assessed on an ongoing basis throughout the life of an investigation or Agency case. Since you are assessing safety every time you see a child or family, the FACES safety assessment allows for updates. Every safety assessment update should be documented in FACES within 24 hours of the change in assessment.

Signs of Present Danger

In consideration of safety you must assess for signs of present danger. *Remember that a sign of present danger is defined as a reasonable cause to believe that a child is, has recently, or could be in the near future in immediate danger of serious harm.* The sign of present danger does not need to be occurring in your immediate presence but when considering it, you should keep in mind the incident(s) or concern(s) that prompted your involvement with the family. Remember that signs of present danger are not always fault-based; they are simply a reflection of the level of danger posed to a child. *(For additional information on signs of present danger, see **Safety Planning & Interventions**).*

EXAMPLE #1

A 2-year-old child is found wandering in the street without supervision. Neighbors contact the police, who respond and call for CPS assistance. By the time the CPS worker responded the mother was located and able to provide care.

In this instance, there was a sign of present danger in that the young, vulnerable child was without appropriate adult supervision. Remember that the safety decision will always be based on your assessment of a number of factors, including the parent's protective capacities and the child vulnerabilities. (See signs of present danger under the Safety Assessment Criteria in the appendices). The caretaker appears to be unable to provide proper care or control of the child's immediate needs for sufficient supervision... to protect the child from immediate danger of serious harm.)

EXAMPLE #2

A 4-year-old arrives at school with a black eye. The school fails to report this information to CFSA until two weeks later. The child then discloses that her mother had punched her in the eye because she

spilled her milk. The school staff confirms witnessing the injury and when you interview the child, she also confirms that she was injured. By the time you observe the child, however, the injury is no longer visible because of the delay in reporting.

Here you have a credible reason to believe that the child suffered from an injury inflicted by his parent. (See sign of present danger #1- a child has received serious physical harm or injury that appears to be inflicted.) The safety decision will, again, be based on your overall assessment of a number of factors, including the parent's protective capacities and the child vulnerabilities.

If you have any concerns regarding the potential level of danger and/or you are not certain whether it is imminent, you should consult with your management team.

Protective Capacities

Protective capacities are the ability and willingness to utilize internal and external resources to mitigate or ameliorate the identified safety and risk concerns and to support the ongoing safety of the child. A protective capacity is a specific quality that can be observed and understood to be part of the way a caregiver thinks and feels that makes him or her protective. For example, there may be a non-offending caregiver in the home who is able to supervise interaction with the offending caregiver, provided that the offending caregiver does not pose a danger by his/her mere presence.

Protective capacities are distinguished from controlling or supplementing safety interventions by the fact that interventions suggest a specific action or actions that were taken to protect the child. For example, if a non-offending caregiver chooses to protect their child by removing the offending caregiver from the home, s/he would have exercised a safety intervention. While it is true that this caregiver likely has significant protective capacities, it was actually the safety intervention that protected the child.

Safety Decisions

A safety decision is ultimately your conclusion as to whether the child is in immediate danger of serious harm and what is protecting the child, either through mitigating factors and family strengths, or by prompt interventions put in place by CPS to control safety threats. All of the information you gather during the safety assessment will be used to support this decision. Keep the following decision options in mind as you plan your investigation and assessment:

- No signs of present danger were identified at this time. Based on currently available information, the child(ren) is/are not likely to be in immediate danger of serious harm.
- One or more signs of present danger were identified, however, the child(ren) is/are not in immediate danger of serious harm and/or the existence of protective capacities offset the threat of serious harm for the child(ren).
- One or more signs of present danger were identified, which place the child(ren) in immediate danger of serious harm, and controlling and/or supplementing safety interventions have

been initiated. With these controlling or supplementing safety interventions, the child(ren) will remain in the home at this time.

- One or more signs of present danger were identified, which place the child(ren) in immediate danger of serious harm and removal to foster care or an alternative placement (or continued placement) is the only controlling safety intervention possible for the child(ren).
- One or more signs of present danger were identified, which place the child(ren) in immediate danger of serious harm, but caregiver(s) has refused access to the child(ren) or fled, or child(ren)'s whereabouts are unknown. Appropriate legal/investigative actions are being taken.

Thorough documentation of your safety decision is key. The safety decision must specifically document **WHY** there is or is not imminent danger (based partly on allegations) or how the immediate danger has been ameliorated. You must explain what information you considered in coming to your decision and, if applicable, indicate any next steps related to safety.

Pointers for Safety Decisions

At times there will be no immediate sign of present danger (such as when it is clear that the allegation is untrue or when a child is safely hospitalized but could be in danger when discharged). You must select the safety decision that is appropriate at the time you are completing the assessment and then update the decision as needed.

Remember that many of the safety factors have a caveat that indicates that a certain condition or behavior (substance abuse, violence, etc.) *suggests* that the child is in immediate danger of serious harm. In most situations, you need to associate the concern that caused or could cause serious harm with the impact or potential impact on the child.

When a child is removed, documentation of the safety decision is critical. The Agency must provide a legal basis for this decision and therefore, it is your responsibility to delineate why removal was the best possible option.

As noted above, even when you have not located some or all of the family, the safety assessment must be completed within 24 hours of receipt of the Hotline call. At times, the safety decision will indicate that there are potentially immediate safety factors and that a child or children has not been able to be accessed. You must clearly indicate additional next steps to locate and assess the child, including possible legal action.

SAFETY PLANNING AND INTERVENTIONS

At times during the course of investigating allegations of abuse and neglect, you will find safety concerns for a child. The information presented below will assist you in determining when and how you can create a safety plan. Within a safety plan, specific actions will be outlined, and the parent or caregiver will be held accountable for the fulfillment of those actions to protect the child in the home. In the event that a “sign of present danger” puts the child at risk for imminent harm by a caregiver, this section will discuss all of your options for safety planning.

As the CPS investigator, you must **always** address immediate concerns of serious harm to a child. But since no case circumstance is exactly alike, it is critical for the well-being of the child and the family that you tailor the intervention and the safety plan to the individual circumstances.

Safety decisions must always be discussed with your direct supervisor or member of your management team. If you become involved in a situation in which a child or children may be in immediate danger you must contact your management team for consultation prior to leaving the scene, unless your own physical safety is in jeopardy. When a child is left in a potentially unsafe situation, even for a short period of time, most importantly it does not protect the child. It also sends a mixed message about the exact severity of the safety concern and may allow for the child’s whereabouts to become unknown or be taken out of the jurisdiction.

REMINDER: *All safety interventions must be clearly documented in FACES on the safety assessment screen and in the contact notes.*

Please remember that a “sign of present danger” does not automatically mean that a child must be removed from the home. It does mean that you must ensure that the sign of present danger is mitigated, and thus that the child is safe.

CFSa has specific practice guidelines regarding safety planning with caregivers. The first consideration is to ensure the safety of the children and the second is to protect the rights of the child's parents or caregivers. If CFSa has determined that a caregiver is “unsafe”, the caregiver cannot make a safety plan for the child. One or more of the following several reasons may also prevent participation of the parent:

- Lack of court involvement may prevent safety planning because without it, the Agency cannot exert legal authority for telling a caregiver where their child must live or stay. Part of safety planning is the ability to dictate certain restrictions for the child's living environment.
- Once a caregiver has already created an unsafe situation for the child, it is presumed that the caregiver will not, cannot, or may not make a safe and appropriate decision for the child's care.
- If the Agency cannot for whatever reason ensure long-term follow-up to the plan, services to support the plan, and/or the future safety of the child, it will not include the caregiver in safety planning.

Determinations of an “Unsafe” Parent or Caregiver

The first decision you must make when determining whether the parent is “safe” or “unsafe” for involvement in the safety planning process is whether or not the child is or would be in danger while under the direct care of the parent. Please refer to the safety planning flow chart in the appendix. When you make such determinations, you must be aware that there are certain situations in which a parent may be a safe caregiver for one child but for not another (e.g., when one child has been physically abused but other children are not similarly situated and therefore not in danger). The following examples apply to caregivers who have been deemed as “unsafe” and are therefore not considered appropriate for involvement in the safety planning process (i.e., the child may be removed from the home):

- The child's caregiver is determined to be the direct cause of imminent danger to that child. In this situation, the caregiver shall not be allowed to create a safety plan that avoids removal.
- There is a lack of lucid reasoning on the part of the caregiver. Causes may include drug use, alcohol use, and/or mental health concerns. In those situations, if there are imminent safety concerns, a removal must occur.
- The parent has been arrested and is therefore “unable” to care for their child, thus creating a sign of present danger.

If a caregiver is arrested for any crime related to child safety or crimes against children, they are not considered a safe caregiver. These crimes may include (but are not limited to) any of the following charges:

- Child cruelty charge (e.g., First, Second or Third-Degree charges, Attempted Assault, etc.)
- Simple assault on the child
- Domestic dispute in which the child is injured or exposed
- Any other arrest related to child abuse or neglect (such as driving a car with a child who is

not placed in a proper safety seat)

Other crimes that would not inherently constitute a threat to a child's safety may cause a safety concern due to the situation. For example, driving under the influence would not immediately warrant safety concern for children but it would constitute a safety concern if the children were in the car. Another example would be possession with intent to distribute drugs *in the presence of the children or in the home where the children normally reside*.

There may be exceptions to this general rule, such as when the arrest is related to only one child and the other children are therefore not considered to be in danger. In these situations, you should consult with your management team and CFSA's legal department regarding whether safety plans can be put into place with the parent's participation.

- There will also be situations during your investigations when a parent is not arrested but you believe, based on your assessment that the child would not be safe to remain with the caregiver. This might be a situation where the caregiver has physically or sexually abused the child, or the parent has failed to protect the child, or a neglect concern has put the child in immediate danger of serious harm. In any of these situations, *if the child is believed to be unsafe and no safety plan can be put into place, then the child should be removed*.

Your decision regarding safety planning may be different when there is another parent and/or legal caretaker for that child, who may or may not live in the home. When assessing whether the other parent or legal guardian can provide care, one of the determinations that should be made is whether that parent is a *legal* parent, i.e., their parental rights are intact, and their names are on the child's birth certificate, and/or they have been legally determined in court. You must fully assess the individual to determine if the children would be safe in their care. This assessment must include all aspects of child safety. This **MUST** also include an assessment of their knowledge of the abuse and/or neglect allegation that was reported to have occurred in the home of the other caregiver.

Note: a caregiver who has knowledge of abuse or neglect but who does not take action to remediate the abuse or neglect is not an appropriate caregiver for safety planning purposes. If you determine that the other parent or legal guardian is not a safe and appropriate caregiver, you should explain to them that they will be assigned an attorney at the initial hearing, that they should attend, and that they can discuss custody with their attorney.

REMINDER: If you decide that a child must be removed, ***you cannot place a child with an unlicensed caregiver***. If there is a friend or family member who is a licensed foster caregiver, you may consider placing a child with them provided that the foster placement is available and the Placement Services Administration has authorized the placement.

Sometimes, during the Family Team Meeting (FTM) after the removal, the family will attempt to create a plan for the child to reside with another individual. *Again, no child can be placed with an unlicensed caregiver*. The

proposed caregiver must apply for licensing as a temporary foster care provider. The caregiver from whom the child has been removed can no longer make a plan.

Determinations of a “Safe” Parent or Caregiver

Even when arrests are involved, a caregiver may be considered safe if the crimes are non-violent and are not related to child safety (e.g., driving with a suspended license, use of drugs outside of the home, failure to pay moving violations or parking tickets, etc.). Thus, generally, these caregivers can plan for their child(ren)’s safety at the time of their arrest. If, however, the Agency has open involvement with the family (either an investigation or a case), then CFSA must ensure that the home environment where the child is staying is appropriate. If it is not, the child can and should be removed.

If there is a secondary caregiver in the home, you must assess that person’s role in caring for the children PRIOR to the event that resulted in the arrest or unsafe situation. If that person is found to be acting *in loco parentis*, it is possible that the secondary caregiver can take responsibility for the children. You must assess to see if the secondary caregiver is appropriate. Both the primary and secondary caregivers MUST be in agreement with the secondary caregiver caring for the children. You must also consider the length of time that the secondary caregiver would conceivably be assuming parental responsibilities and determine whether this affects the appropriateness of the plan.

In order to participate in the safety planning process, the caregiver must not be subject to any of the “unsafe” descriptions listed earlier in this section. For example, if the primary or secondary caregiver is not lucid and therefore unable to agree to the plan, the plan cannot be made. The exception is if the secondary caregiver is the biological or legal caregiver. Then, if that person is an appropriate and willing caregiver, the children may be left in their home. You must still assess whether the primary caregiver will return to the home, and whether the plan is appropriate.

At times, you may assess a child to be safe with their parent but both the parent and you believe that an intervention for the child will improve their well-being. At those times, the parent may want to safety plan for the child to stay with a relative or at a community agency. These situations allow for the parent and child to “take a break” from internal family stressors. Because you believe that the child is safe to remain with their parent, the parent is allowed to plan, and you can assist with the planning.

At other times, you may assess that a child is not safe in their home environment, but would be safe with their caregiver outside of the home environment. Examples of this might be a home that is in a deplorable condition or does not have utilities. Even though there may be neglect occurring because a parent has failed to pay utilities or failed to ensure a clean home environment, the child is not in danger with their parent. The parent can plan for themselves and their children to move to a safe location.

Other Factors to Consider

When determining if a safety plan can be created with a family, there are other factors to consider:

- Does the family have a prior history with CFSA or another jurisdiction's child welfare agency?
 - If the family does have prior history, and safety plans and/or interventions have been put into place in the past, you need to determine if it is appropriate to continue safety planning or if the child needs to be removed.
- Is the parent cooperative?
- Does the parent acknowledge the safety concerns and/or admit responsibility?
- Is the child fearful of remaining in the home?
- Is the parent capable of following the safety plan?
 - For example, if the parent is a chronic substance abuser or has significant mental health concerns, even if they are lucid at the time you create the safety plan with them, they may not be able to follow the plan for any period of time.
- Is there a reason to believe that due to Agency involvement, the child would be in danger if left in the home?
 - For instance, in some cases, parents become angry because their child has disclosed information related to abuse or neglect. Even with a safety plan, when CFSA has left the home, the parent might be very angry and harm the child.

Remediating Neglect with Safety Plans

In many cases, neglect concerns can be remediated by the provision of resources and services. The following list offers ways in which causes of neglect can be remedied through a safety plan with the family to avoid removal and protect the child. This list is not exhaustive and should be used only as a guide.

Special Note: there may be times when the following interventions are not appropriate. For example, an intervention may have been put into place in the past but was not effective on a long-term basis. You must use your clinical judgment along with input from your management team to determine if these interventions should be implemented. Such determinations are not to conclude the disposition of the allegation.

Neglect Allegation	Possible Plans or Service Provision	Other Considerations
Inadequate Food	Grocery Vouchers, Food Bank Information, Budgeting	How often does this happen? Is it due to poor budgeting? Do the parents have limited income and are not receiving assistance? Is the parent using their money or food stamps to buy alcohol, drugs or other non-necessity items?

Inadequate Shelter (e.g., deplorable housing)	Homemaker services, family will stay in a shelter or hotel	Is the poor housing condition the fault of the parent or the landlord? Does the parent make efforts to ensure appropriate housing?
Medical Neglect	Immediate Medical Care	What is the reason for the neglect?
Exposure to Criminal Activity	Notify law enforcement	Is the parent committing the crime? Is there someone else in the home? Does the home belong to someone else?

WRITTEN SAFETY PLANNING

A safety plan must be written and consist of the following sections:

- The name(s) of the child(ren) who are at risk due to the unsafe situation.
- Description of the unsafe situation - please note – some caregivers will have difficulty signing a document that indicates they may have caused their child to be unsafe. You should write in this section that there are allegations that are in the process of being investigated.
- List of responsibilities for the caregiver, for example, “refrain from using physical discipline”, “clean up the home within 3 days”, “move cleaning products to a shelf out of a child’s reach”, etc.
- List of responsibilities for CFSA, e.g., provide parenting classes, therapy services, etc.
- Consequences for failure to follow the safety plan, e.g., possible removal of the child(ren).
- An agreement from any person involved in the child’s care regarding the plan.
- Signatures: CPS investigator, all caregivers, and the assigned CPS supervisor (upon return to the office).
- Overall time frame for the safety plan, e.g., alleged perpetrator must leave the home until the investigation is complete, etc.

Please see the appendix for the general safety plan template. Previous created forms must be discarded and each written safety plan must be customized to the family at hand.

Supervisory Approval of the Safety Plan

Once you have developed the written safety plan with the parent's or caregiver's full participation, you should meet with your supervisor to review the plan. Upon approval, the supervisor shall sign the plan and the original will be placed in the official hard copy case file. A copy of the plan should be given to the family. ***Reminder: you are required to receive supervisory approval.***

THE DISPOSITION DECISION

One of the most important decisions you will ever make as a CPS social worker is the disposition decision regarding the reported allegation and any other allegations uncovered during your investigation. The following information will inform the basis of your determination and **MUST** be documented clearly in FACES in order to justify your disposition:

- child's statements
- maltreater's statements
- collateral statements
- physical evidence
- medical findings
- records or reports

After the completion of a thorough investigation that includes the assessment procedures, you must then determine only one of three possible disposition decisions for each allegation and for each child, individually:

- substantiated
- inconclusive
- unfounded

The decision to substantiate allegations depends on the answer to this main question:

Is there sufficient *credible evidence* to support
the disposition of child maltreatment?

Substantiated –You must substantiate an allegation if there is evidence to believe it occurred. The DC Official Code 4-1301.02 indicates that a substantiated report is “A report made which is supported by credible evidence and is not against the weight of the evidence.”

Reminder: You may use credible information obtained during the investigation even if you yourself do not observe the maltreatment, e.g., a credible mandated reporter informed you that the child had an injury, that the parent was observed punching the child, etc.

Inconclusive –The disposition of an allegation should be Inconclusive if there is insufficient credible evidence to substantiate, however, there is some or conflicting information to indicate that the abuse or neglect may have occurred. The DC Official Code defines an Inconclusive report as a report “which cannot be proven to be either Substantiated or Unfounded.”

Unfounded –An allegation should be Unfounded if there is insufficient credible evidence to believe that abuse or neglect has occurred. The DC Official Code defines an unfounded report “as a report which is made maliciously or in bad faith or which has no basis in fact.”

Considerations

At times, situations may be resolved during the course of an investigation, either due to the parent making changes or CFSA’s interventions. You must determine whether the allegation that was reported should be substantiated based on the evidence of whether the neglect or abuse occurred or was occurring prior to CFSA involvement. Just because the neglect or abuse has been remediated, it does not mean that the disposition should be Unfounded.

Special Note: *the disposition is ultimately considered an Agency decision, not an individual social worker's decision. Your management team must approve the disposition decision. You may also seek CFSA – OGC assistance after conferring with your management team.*

You must practice with consistency. As noted above disposition decisions are based on facts and not your emotional response to the situation. There was a historical option within CPS to “warn and counsel” a caregiver who had abused or neglected a child but the matter appeared to be isolated or the caregiver was remorseful or the finding would impact the caregiver’s employment. This option does not exist any longer; specifically for the concern of consistency and fairness in practice. If the facts of a case warrant substantiation then your decision must be consistent with this.

Remember that all caregivers who are subject to an inconclusive or substantiated finding against them have the option of requesting a Fair Hearing. You must send the standard paperwork for this process at the conclusion of your investigation, place a copy of the notice letter in the file and document in contacts that this paperwork has

been sent to the caregiver. Failure to do so may result in the caregivers name being removed from the CPR do to lack of notice.

All disposition decisions must be entered into FACES under the Assessment Findings screen. The Results tab is used to note any changes made to dispositions and the results of a fair hearing. The Results tab should only be used by social workers to document (via check box) if the investigation was a joint investigation and/or whether criminal proceedings have been initiated.

STRUCTURED DECISION MAKING (SDM) RISK ASSESSMENT

Risk is the likelihood that a child may be abused or maltreated in the future. The SDM risk assessment tool assesses families for low, moderate, high, or intensive probabilities of future abuse and/or neglect. These risk levels, along with your clinical judgment and the disposition decision, will guide your decision whether or not to open a case, whether to refer the family to a collaborative, or whether to close an investigation with no further services.

The risk assessment must be completed toward the end of the investigation and within 30 days. It is based upon a full assessment of the family and thorough knowledge of the strengths and challenges therein.

Note: *The risk assessment must be completed on the household that is the primary residence of the child. If the alleged maltreater resides in a different household but continues to function as a caregiver and is entitled and obligated to provide for the safety and well being of a child, a risk assessment on that household should also be completed. If the child is a member of two households, and both caregivers are identified as alleged perpetrators, a separate family risk assessment must be completed for each household.*

The risk assessment must be clearly documented in FACES in the risk assessment screens. Your overall documentation should address the prominent risk concerns and any needed services. There are three distinct parts of the risk assessment. All of them must be completed. **Remember:** *You must create your household(s) in order to be able to complete the risk assessment.*

Risk Assessment Screen

- Document all answers to all questions utilizing the help tool to clarify definitions in each category
- You should be very familiar with the definitions for each multiple choice question in order to accurately assess the risk level.

Assessment Narrative

- Document Risk Factors in a list format, including those identified on the risk assessment screen and others.
- Document family strengths, as appropriate.
- Document the family's support system, including fathers, relatives, and "kin." This should include what type of support they provide.
- Document the overall level of risk.

Conclusion

- Not accessible until all questions on the risk assessment have been answered and the narrative assessment completed.

- Document whether or not overrides are applicable.
- If a discretionary override is selected, the final risk level will change to one level higher than the scored risk level. **Note:** if a discretionary override is selected, you must explain why the discretionary override is appropriate.
- Request Approval from your Supervisor.

RISK FACTORS

Child Risk Factors

- Premature birth
- Positive toxicology or exposure *in utero*
- Birth anomalies
- Low birth weight
- Temperament: difficult or slow to warm up
- Physical/cognitive/emotional disability
- Chronic or serious illness
- Childhood trauma
- Mental health concerns
- Age
- Behavior problems
- Special needs

Parental/Family Risk Factors

- Personality Factors
- External locus of control
- Poor impulse control
- Depression/Anxiety
- Low tolerance for frustration
- Feelings of insecurity
- Lack of trust
- Insecure attachment with own parents
- Childhood history of abuse
- High parental conflict, domestic violence
- Family structure – single parent with lack of support, high number of children in household
- Social isolation, lack of support
- Parental psychopathology
- Substance abuse (past or present)
- Separation/Divorce, especially high-conflict divorce
- Age
- Number of children
- High general stress level
- Poor parent-child interaction, negative attitudes and attributions about child's behavior
- Inaccurate knowledge and expectations about child development

Social/Environmental Risk Factors

- Low socioeconomic status
- Stressful life events
- Lack of access to medical care, health insurance, adequate child care, and/or services
- Parental unemployment
- Homelessness
- Social isolation/Lack of social support
- Exposure to racism/Discrimination
- Poor schools
- Exposure to environmental toxins
- Dangerous/Violent neighborhood

- Community violence

SERVICE PROVISION

Every family that has an open investigation should be offered services. These services may include rehabilitative services, referrals to the Collaboratives, or other community-based services. In some cases, the service may be foster care, if the children are found to be in imminent danger and cannot remain safely in their homes. The information that you obtain in your investigation will guide your decision-making for service provision for the child(ren) and family.

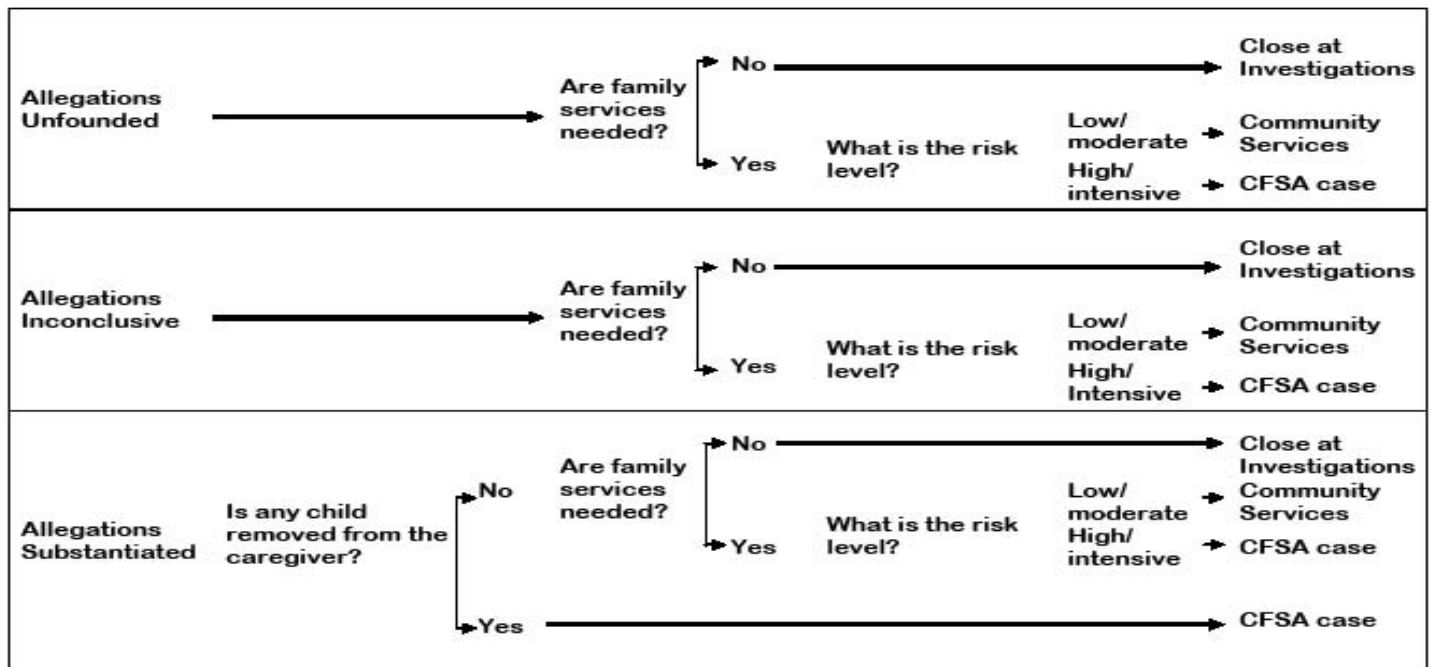
Remember: CPS provides services to protect children from the immediate danger of serious harm, and to reduce risk and resolve identified problems and underlying conditions that create risk. The **risk level** and **disposition of allegations** determines how and where families can and do receive services.

You should make every effort to initiate services that will help protect the children as soon as possible or at least within the 30-day investigation timeframe. Depending on the outcome of the investigation, you or the FSW or the on-going worker must follow up on all service referrals. You must ensure that the referrals were received by the appropriate agency and that there has been outreach to the families.

If your clinical judgment determines that additional or different services would benefit the family, you should explore those services with the family and with your management team. If the family chooses not to accept services (assuming that they have that option – see below), then you do not have to provide additional services. Referrals to the Collaboratives are encouraged as appropriate to meet the needs of the child and family, and to maintain safety while reducing risk.

Note: the federal Child Abuse Prevention and Treatment Act (CAPTA) requires that we refer children ages 0 to 3 for early intervention screening if they have been subjects of a substantiated investigation. Within 72 hours of the disposition, you must refer such children to OCP for this referral to *Child Find* under the Office of the State Superintendent of Education (OSSE) - Infants and Toddlers with Disabilities Division.

CPS Investigation Outcomes



Case Management

Health Families Thriving Communities Collaborative Referrals

You can submit a referral to the HFTC Collaboratives at any point during the course of the investigation. These referrals can be made regardless of whether the allegations are Unfounded or Substantiated.

To refer a client to the Collaborative, please have the family sign a Release of Information form, then fill out the Collaborative Referral form, complete the risk assessment and submit this as a packet to the Collaborative Liaison.

Agency Cases

When you have a risk level that is high and the case is substantiated, you need to generate an open case with CFSA.

If the risk is high and the allegations are unfounded, you must offer supportive services to the family but know that these services are voluntary. Document the offer of services and the family response in writing.

If you still believe that the family could benefit from the Collaboratives' services, you may also advise the family that they can seek help from the Collaborative on a walk-in basis.

Emergency Services

Collaborative Referrals

You can submit a referral to the Collaboratives at any point during the course of the investigation. These referrals can be made regardless of whether the allegations are Unfounded or Substantiated. *Note: you cannot refer a case to the Collaborative if the SDM Level is high.*

To refer a client to the Collaborative, please have the family sign a Release of Information form, then fill out the Collaborative Referral form, complete the risk assessment and submit this as a packet to the Collaborative Liaison.

At Risk FTM

The At Risk FTM is designed to assist the family in making a family plan that will resolve crises and/or prevent the removal of the children. The At Risk FTM allows various family members to express their concerns and with the help of the facilitator and CFSA social worker, come up with a plan to ensure the safety of the children and the stabilization of the family. A referral for an At Risk FTM can be made at any point during the investigation. You must submit the referral on-line.

General Referrals

While conducting an investigation, you may encounter situations where the family is in need of emergency services and cannot wait until the case is re-assigned to an on-going unit. It is your responsibility to immediately address these needs through a referral of services. These may include, clothing vouchers, food vouchers, mental health services for people in crisis, furniture vouchers, etc. Services referred by the on-going worker may include psychotherapy, housing assistance, mentoring, homemaker services, etc. **Remember:** these are general considerations that may need to be addressed on a case-by-case basis.

MANAGING REMOVALS

REASONABLE EFFORTS

As a first course of action, you are required to make **reasonable efforts** to prevent the removal of children from their families. If there is an immediate threat to the child's safety and well-being, however, CPS works closely with the Office of Placement Services to provide the most suitable and nurturing foster care environment available. Achieving safety, well-being, and permanency is the final goal for all children. Please refer to the CPS Investigations Policy for more information on reasonable efforts.

Reasonable Efforts –any activity that purposefully attempts to protect and preserve the in-home status of a child or a child's goal of reunification. Such efforts may include (but are not limited to) assessing imminent threats to the child's safety, developing alternative methods for in-home safety plans, and/or identifying people and resources to help prevent child placement.

When conducting an investigation of child abuse or neglect, you must assess whether any child who is at risk should be removed from the home or can be protected by the provision of resources (e.g., making a referral or putting in services to ameliorate the abuse or neglect, etc.).

It is important at this point to realize that District law does not specifically define reasonable efforts in regard to the prevention of a child's removal. *DC Code § 4-1301.09a* does, however, require the following particulars to be considered (under the section on *Reporting Child Abuse and Neglect*):

- In determining and making reasonable efforts under this section, the child's safety and health shall be the paramount concern.
- Reasonable efforts shall be made to preserve and reunify the family by the Agency, although there are a few exceptions.
- These reasonable efforts shall be made prior to the removal of a child from the home in order to prevent or eliminate the need for removing the child, unless the provision of services would put the child in danger.

REMOVAL DECISIONS

The decision to remove a child from a caregiver is a profound change for a family. This decision must only occur after reasonable efforts have been made to keep the family intact, unless the exigent circumstances negate the need to make such efforts, and a subsequent determination has been made that child vulnerabilities and safety concerns outweigh the protective capacities of the caregiver(s). *All decisions to remove a child must be made in consultation with your supervisor, who will also confer with their respective program manager, or the program manager on duty.*

In the likelihood that the removal decision is being made while you are in the physical presence of the child or children, *you should not leave the scene*. The very nature of a removal is stressful to all parties and certain potential exists for escalating tensions that may result in additional harm to the child. In many situations, it may be necessary to involve the police. An officer can serve as a witness to the circumstances of the removal as well as provide a level of stabilization.

WORKING WITH CAREGIVERS DURING REMOVAL

Engagement

Treating clients with respect is particularly vital during the removal process. Even under the best of circumstances, a removal will undoubtedly be emotionally charged. As the CPS social worker, you are in a unique position for setting the tone for future cooperation between the caregiver and a team of other child welfare professionals. If the caregiver is physically present during the removal, it is important that you use engagement skills, and take appropriate opportunities to highlight the strengths of the family, in spite of the safety concerns. It is equally important that you clearly identify the reasons for removal and that you make efforts to explain the removal process to the caregiver(s) as much as possible. (If the caregiver is too tense for communication at the time of removal, information should be left with them and follow-up should occur in a timely manner to help the caregiver understand this critical process.) Throughout the process, continue to build the foundation for a positive working relationship and when appropriate, reaffirm your ultimate goal to reunite the family.

***Remember:** the primary goal in the removal process is always to secure the immediate safety of children and then, as soon as feasible, safely reunite the family. Only in the most severe situations, such as an intra-family homicide or in some cases incest, would a CPS social worker not strive initially to ultimately reunite family members.*

Legal Notification and Discussion

All caregivers should be provided with a written *Notice to Appear in Family Court*. This is a standard form (see appendix **X**) that should be completed and signed by the CPS social worker. If a caregiver cannot be accessed (due to arrest, unknown whereabouts, etc.) this form should be left at the caregiver's residence.

If the situation allows, you should make every effort to begin a discussion with the caregiver regarding the court process. In so doing, you must play the role of advocate to help the caregiver fully comprehend the importance of attending the initial hearing, paying attention, and understanding their legal rights. At a minimum, the following procedures should be described:

- An attorney will be provided to the caregiver or, if they are able, they can hire their own.
- The caregiver will have an opportunity to request that the presiding judge hear their side of the events.
- Services are available to help their family, but the services are optional.
- The judge will make a decision about whether the removal was justified and whether the child(ren) should remain in shelter care.

Family Team Meetings

All caregivers must receive the standard brochure on the Family Team Meeting process. When explaining or discussing the brochure with the caregiver(s), ask them if there are any potential relatives who may serve as support. Relate any names and contact information to the FTM unit via the FTM referral (*see section on*

FACES documentation below). Be prepared to explain CFSA policy about placement with relatives, including the temporary licensing process if applicable. The caregiver must fully understand that placement with relatives cannot occur immediately upon removal unless they are already a licensed foster care provider and must be cleared through CFSA's Placement Services Administration.

Talking with the Caregiver about the Children and Obtaining Important Items

The caregiver is always considered the expert on the child, even if he or she is facing child maltreatment allegations. If the caregiver is physically present during the removal process, try to learn as much as possible about the child's basic care:

- Name and contact information for the child's primary physician, including status of immunizations, specific health issues, and/or general health care.
- Determine if the child has special needs (physical or emotional) and what implications these may have for the child's placement. Depending on the level of special need (wheelchair bound, medically fragile, etc.), you may need to make arrangements for appropriate transportation and care of the child. Confer with your management team in these situations.
- Obtain medication (if applicable) from the caregiver and give these to the medical professional who examines the child at the time of removal (see section below on Medical Screening under Taking Children into Protective Custody). If the caregiver refuses to provide medications, this should be documented.
- Obtain important paperwork (if possible) regarding the child, including the birth certificate, social security card, and health insurance card.
- Obtain information about the child's education, e.g., school enrollment, specialized services or programs (such as tutoring). Special Note: keeping a child's routine in place is one very specific way to reduce additional trauma as the child adjusts to the removal.
- Obtain appropriate clothing for the child, if available. (If clothing is significantly deteriorated or otherwise uninhabitable, it should be left behind.) Find out if the school age child(ren) wear uniforms and what the expected attire is for the child(ren). Endeavor to transport the clothing in an appropriate suitcase or other carrier. If clothing cannot be obtained at home, determine if any emergency clothing can be obtained through CFSA's Partners for Kids in Care (formerly Office of Volunteer Services) or through requesting a CFSA clothing voucher. If the child was interviewed at the Children's Advocacy Center, the child may qualify for a few sets of clothing from that organization.
- Determine if the child has any special habits (e.g., a particular bedtime routine) or items (e.g., favorite toy or stuffed animal) that would help ease this transition.

Legal Rights of Additional Caregivers

If there are legal caregivers for a child from whom the child is not being removed, efforts should be made to locate these caregivers and assess their willingness and capacity to serve as advocates and/or nurturing caregiver figures. This may include absent caregivers or caregivers with limited involvement. All biological parents and/or legal caregivers should be given notice to appear in court if their whereabouts can be determined. When possible, this notification should be given prior to the initial hearing. After the initial hearing, the assigned Assistant Attorney General (AAG) will make arrangements to conduct a diligent search for parties of interest who will need notice of the court proceedings.

Communications between the Caregiver and Child during the Removal

Clinical judgment should be used when determining to what extent there should be communication (either in person or via telephone) during the removal process. ***Special Note:** unsupervised contact is to be avoided both for the best interests of the child and to protect the investigation process. This should be explained to all parties. Any discussion of the investigation at hand should also be avoided.*

Visitation

At the initial court hearing, the presiding judge will determine whether visitation between the caregiver(s) and child(ren) is appropriate and/or should be supervised. As the CPS social worker who first assessed the family situation and engaged with the child(ren) and caregiver, you should be prepared to make a recommendation on this issue and to provide a supporting rationale. Note: Please refer to the visitation Policy for more information.

TAKING CHILDREN INTO PROTECTIVE CUSTODY

1. Communicating with Children during Removal

- Use a soothing/appropriate voice to put the children at ease. Be genuine.
- Use vocabulary that is easy for the children to understand and define words, such as “placement”, in simple terms.
- Help the children understand what is happening and why they are leaving the home, including the reason for placement (as appropriate). Recognize that some information is too complicated for younger children.
- Make sure the children understand that emergency placement is *not their fault* and *they are not being punished* for anything.
- Describe step-by-step events that will take place throughout the placement process.
- Use engagement skills to encourage the children to express fears and concerns about placement, and then address them.
- Identify the names of the staff the children will encounter, their job functions, and possible questions the staff may ask children.
- Assure the children that their desire or lack thereof, to contact family during the removal will be considered.
- Encourage children to bring personal belongings that can be helpful during the transition into care.

2. Medical Screening and/or Medico-Legal Examinations

All children entering shelter care must receive a medical screening prior to placement. This screening is coordinated through the Healthy Horizons clinic located in the CFSA main office.

Some children will need to have a “medico-legal” examination, which is an examination specific to physical and sexual abuse. As noted throughout this document, CFSA's provider of choice for these examinations is the Child and Adolescent Protection Center (CAPC) within the Children's National Medical Center (CNMC). The Emergency Department at CNMC is also an option. The physician completing this examination should make a written notation that the child is "medically cleared for placement." The paperwork should then be taken to the Healthy Horizons clinic to ensure that the child is enrolled.

3. Ongoing Medical Care

Healthy Horizons will ensure that all children entering care are set up for their standard medical, dental, and vision appointments. As noted above, if a child is not medically screened at Healthy Horizons (e.g., in the case of medico-legals or children entering care directly from a hospital facility), they must still be enrolled in the Healthy Horizons program afterwards to ensure that they are set up for their ongoing medical care.

4. Mental Health

If a child presents any current mental health distress (e.g., the child is suicidal, homicidal, psychotic, etc.) an

immediate mental health assessment is required.

Additionally, all children entering care, age 8 and over, must receive a mental health assessment from the CFSA Office of Clinical Practice within ten days of removal. A consult between OCP and the child's caregiver must occur for any child under age 8.

5. Children ages 0-3

Children ages 0-3 are in a state of high vulnerability in general but particularly during a removal process. Most of these children are not verbal and may not understand the removal process. For infants, critical bonding experiences can be disrupted during removal. Special assistance may be required. It is important that you make concerted efforts to determine the basic care needs of infants (feeding method, allergies or special care needs, etc.). Remember, CFSA is mandated to refer all children in this age range through CFSA's Office of Clinical Practice (OCP) to the District's 0-3 Early Intervention Program.

TEAMING WITH EXTENDED FAMILY AND SUPPORTS

1. Confidentiality

Remember: *all CPS investigations are confidential.* Conversations with the caregiver can help identify relatives or close friends who may be supportive, including professionals. It is important, however, that communications with these supports occur *only with the proper releases of information or consent of the caregiver.* Be prepared to explain the constraints of confidentiality to these supports so that they understand the role you play and they understand how to best interface with the Agency.

2. Placement with Relatives

Be prepared to explain to families that you do not have the immediate ability to place children with family members. Children may only be placed in licensed placements. However, family members interested in kinship care will be provided with the kinship care licensing packet. Remember that extended family must be thoroughly assessed regarding their attitude toward the children, the caregiver, and the removal in general. In addition, their overall fitness to provide care must be assessed, including suitable housing, and the ability to pass criminal or child welfare background clearances.

Fostering Connections to Success and Increasing Adoptions Act of 2008

This federal law requires that child welfare agencies exercise due diligence to identify and provide notice to all adult grandparents and other adult relatives of a child within 30 days after the child is removed from his or her home.

- CFSA requires that within 30 days of a child's or youth's entry into foster care, the investigator/social worker must use reasonable efforts to identify and locate any absent parent(s), all maternal and paternal grandparents, other relatives and significant non-relatives of the child or youth.
- The investigator/social worker will notify these adult relatives and significant non-relatives of the removal and provide them with information regarding their custodial options. (Exceptions may be made due to family or domestic violence.)

As the CPS social worker, it is critical that you gather information as to adult relatives and significant non-relatives and thoroughly document this information in FACES. This will allow CPS or the on-going social worker to notify relatives and explore them as placement resources when children enter foster care. This information should be obtained from the parent as soon as possible.

3. Family Team Meeting

The Family Team Meeting (FTM) process is a formalized practice for involving family supports in the planning of the children's care. This is a collaborative effort and it is important that their opinions, concerns,

recommendations, and suggestions are heard. As the CPS social worker, you need to be prepared to discuss the family's safety and risk factors that you identified, and to ensure that these factors, both negative and positive, are addressed in the FTM process.

THE PLACEMENT PROCESS:

Coordination with CFSA's Placement Services Administration

1. Call to, or conversation with, Placement Services Administration (AKA "Placement")

Once a final determination has been made to remove a child from the home, you or your management team should contact the Placement Services Administration to discuss the child's specific placement needs. Ideally you should have every child's full name, DOB, health needs, school information, and the reason for removal. This information will be included in the child's Placement Packet (*see #2 below*). Even if all of this information is not immediately available, you must still contact Placement so that they can begin searching best placement options. You can follow-up with the additional information as soon as you receive it.

***Special Note:** there will be times when you must conduct a removal (i.e., a legal removal for a child who needs to remain in a hospital setting). In these situations, you should still notify Placement so that they can prepare for the child's release from the facility and subsequent entry into their best placement option.*

2. Placement Packet

All placement providers (or resource caregivers) receive a green "placement packet" for every child in care. The packet includes the child's medical screening and demographic information. Additional packets can be obtained from the Placement Services Administration.

TEAMING WITH PLACEMENT PROVIDERS

1. Discussion of Reason for Removal

Resource caregivers (i.e., foster parents) should be given as much pertinent information as possible about the child in their care, including the reason for removal. Relevant and detailed information, such as any known previous behavioral issues or current concerns, helps the provider to address the child's individual situation and creates a good foundation for quality care. In the event that there are sensitive aspects of the investigation (e.g., criminal components that require increased levels of confidentiality), discretion should be used regarding the extent of information shared.

2. Discussions Regarding Individual Children

Since each child may naturally respond differently to placement, it is important that each child, including siblings, be discussed individually. Discussions with a placement provider should include distinguishing information about the individual child's concerns or fears, routines, comforts, etc.

3. Medical Care

Medical care for each child should be established through the initial placement screening process. It is essential that any concerns resulting from that evaluation be shared with the placement provider so that the best care possible is available to the child. The placement provider should also be given any information related to special medical needs, upcoming appointments, and over the counter medications that the child may take such as vitamins. ***Special Note:** if the child takes prescription medications, you need to ensure that the prescriptions are filled prior to placement of the child.*

If a child is being discharged from a hospital or has specialized medical needs the placement provider must be included in conversations with medical professionals to ensure adequate preparation for the care of the child.

4. Transportation and Education

As stated earlier, maintaining a child in his or her school placement is a priority during removal. This is an aspect of normalcy for the child and can mitigate the profound adjustments that must be made after removal and placement. ***Special Note:** you should consult with your management team in the event that the child's normal school placement is determined to be detrimental to the child's best interests (e.g., if the child reports being uncomfortable at his/her school as a result of the removal and placement, or if there is a potential danger to the child due to caregiver access, etc.).*

Although placement providers are charged with ensuring that children are transported to school, this may not always be practical or possible. During the initial placement process, you should make every effort to explore

and facilitate other transportation options. For children who have special needs and already receive school busing, transportation arrangements can be transferred directly to the placement provider. For other children in need of transportation services, please contact the OCP educational specialist for assistance.



FACES DOCUMENTATION AND GENERAL PAPERWORK

1. Safety Assessment and Case Connect in FACES

Your determination for removal must be entered into FACES under “safety decision #4” on the safety assessment screen. Once this decision is selected and approved, you will be allowed to complete the case connect and formally open the Agency case.

2. Removal Screen and Legal Status

On the date of removal, you must complete both the removal and legal status screens in FACES. Completion of these screens triggers your ability to complete the mandatory online complaint.

3. Complaints

For every child who is removed, a complaint must be completed in FACES. The complaints are submitted electronically and distributed to DC Superior Court and the Office of the Attorney General (Neglect Section). For further instructions on how to properly file a complaint, please see CPS & the Law section.

4. FTM Referrals

The FTM referral must be completed using the online Universal Referral tool (*see the CFSA intranet*). Please include a brief description of the removal as well as demographic information about the children, caregivers, and support resources. This will be emailed by your management team, along with your approved complaint, to a number of parties in CFSA and in the Office of the Attorney General.

5. School Notification

For children who are enrolled in school and/or child care, notification should be given to the appropriate institution explaining the change in the child's legal custody.

6. 30-A and CAD Forms

The 30-A and CAD (Citizen Alienation Declaration) forms are completed for each child who enters care. This is done after there is a legal Shelter Care finding for a child (which typically occurs at the initial court hearing). These forms can be printed from the 'Reports' section in FACES. The forms need to be signed by your supervisor and then submitted to the CFSA Eligibility Department.

FACES DOCUMENTATION OF INVESTIGATIONS

DOCUMENTATION FOR INVESTIGATIONS

The integrity of the investigative process is preserved only by thorough, accurate, and clear documentation of *every pertinent social work activity that directly impacts the investigation assigned to you*. Your documentation must also include the rationale behind each activity. These written notations protect the safety and well-being of the children being served by the Agency, and they also protect you as an agent of the Agency, as well as the Agency itself.



When you hold yourself professionally and personally accountable for proper documentation, you not only fulfill your obligations to the children and families of the District of Columbia, you also get the credit you deserve for your hard work.

The guidelines highlighted below will help you achieve the level of quality documentation that is expected of all CPS social workers.

MANDATES

- ALL investigation activities must be accurately and clearly documented in FACES within 24 hours of their occurrence.
- It is especially critical to document initial contacts with the family and the safety assessment within 24 hours of receipt of the investigation.
- “Dead ends” must also be included in the documentation.
- It is NEVER acceptable for there to be more than one week that passes without updated investigation activity and documentation.

REMEMBER: if it is not entered in FACES, it didn't happen!

This includes documentation that may be in some other form (Microsoft word, email, etc.). Without entry into the appropriate FACES screen you will not receive credit for the good work you have done!

PURPOSE

- Documentation guides the CPS process.
- Provides a detailed account of the allegations and the investigation outcome.
- Demonstrates accountability on the part of CFSA and the worker.
- Guarantees facts to support any legal action that might be necessary.
- Provides an efficient means for supervisory review and statistical reporting.

KEY DATA ENTRY

CLIENT DEMOGRAPHICS

- Full Name, Date of Birth, Social Security Number, Medicaid Number
- Address and Telephone Number for Caregiver
- Educational Information (Name of School, Attendance Record, etc.)
- Medical Information (Childhood Diseases, Name of Physician, etc.)

COLLATERALS

- Attorneys
- Foster Caregivers
- Relative Providers (note: do not include these in the Client List)
- Service Providers
- Relatives
- Private Agencies
- Other Related Individuals

CONTACTS

- As noted under “**Mandates**” above, contacts must be entered into FACES within 24 hours of the interviews.
- The contact screen should correctly reflect either “attempted” or “completed” so that FACES can appropriately track statistics.
- For reporting purposes, workers should be mindful of the difference between the fields of “clients discussed” and “client participants”.
- Initial contacts with caregivers and/or children should be individually entered and the worker should clearly indicate that each individual was interviewed outside the presence of other individuals.
- Descriptions should be explicit and concise. They should clearly indicate the date of the contact, the location, who was interviewed, the response to the allegations and the responses to the general interview questions. (*Please refer to the IPC section on interviewing for more detailed guidance.*)

The initial contact with the alleged perpetrator or caregiver should also reflect the following:

On (date), this worker conducted a (home, school, office, or other location) visit to the (address of residence, shelter, location of the investigation, etc). This worker introduced (himself or herself) to the (identify subject of the interview), and explained the role of CFSa and the purpose of the District of Columbia child abuse and neglect law, and provided details of the specific allegations contained in the report.

- Core contacts should include the reporting source, FACES search, alleged victim and other children, alleged perpetrator and caretaker, collaterals, and household members. (See individual sample narratives for reporter, caregiver, and child interviews under [Assessment Notes](#) below.)
- The contact with the reporter **MUST** include the word “reporter” in the non-client/non-collateral screen in order for FACES to recognize it. **Reminder:** you should make at least 2 to 3 attempts during the course of the investigation to establish contact with the reporter. If you are unable to establish contact, please notify your management team who will then determine if the investigation can be closed without this core contact.

- Household members do not need to be added as clients, but each contact should reflect the name of the individual in the non-client/non-collateral field.
- For medical and educational contacts, please select “medical/dental” or “education” for the PURPOSE field.

ASSESSMENT NOTES

All narratives shall follow the same basic template. The following examples will guide you on how to enter data in each field.

HOTLINE REPORT

On *(date)*, the CFSA Hotline received a report regarding *(mother and/or father's name)* and *(her, his, or their)* children: *(list children and dates of birth or ages)*. The family reportedly resides in a *(home, apartment, shelter)*, located at *(address)*. The report alleged that...

Document all links, screen outs, and Information and Referrals (I&Rs) under this section (*for more information on I&Rs, please refer to the Hotline Practice Guide*).

FACES SEARCH

On *(date)*, a FACES search was conducted and the following results were obtained:

Document the following information:

- Each prior referral number and a brief explanation of the allegations and/or outcome of the investigation.
- Prior I&Rs and their affiliated outcomes.
- Screened-out reports (indicate the reason for the screen out).
- Prior case history, including the open and close dates as well as the reason(s) for opening and closing the case.
- Any history from other jurisdictions.

REPORTER (CORE CONTACT)

On *(date)*, this worker contacted the reporting source, *(name)*.

Include the following information:

- Any additional facts, details, and/or descriptions relayed by the reporter.
- Efforts or actions taken by the reporter.
- Documentation of interviews with additional reporters due to links or screen outs that took place during the course of the investigation.
- Follow up with the original reporting sources (if the original report was made second hand).

CHILDREN (CORE CONTACT)

On *(date)*, this worker interviewed the child(ren) outside the presence of the *(mother, father, caregivers, caregiver and siblings)*.

Include the following information:

- Reason(s) for the interview being conducted in the presence of an individual (if applicable).
- Child's response to all allegations.
- General appearance of the child.
- Demeanor and interaction of the child with the caregiver.
- Other statements made by the child in reference to general care and well-being.
- Methods of **discipline and supervision** for the children.
- All information discussed in the child assessment guidelines of this guide.

Special Note: *all children in the family must be interviewed.* If there are other children in the family who are not residing in the home, the worker shall include the following information when documenting efforts to establish contact with these children and their caregivers:

- Reason for the child not living with the family.
- Legal status of the child (informal arrangement, temporary custody, permanent custody, guardianship, or other).
- Visitation status of the child with the family or siblings.

Special Note: *in some cases, there may be complications surrounding the definition of "family." The worker should consult with the management team for how to proceed with documentation.*

CHILD ADVOCACY CENTER

Document a summary for each forensic interview conducted at the CAC.

PARENT OR CAREGIVER (CORE CONTACT)

On *(date)*, this worker conducted a visit to the *(residence, shelter, location of the investigation, etc)*. This worker introduced (him or herself) to the family, and explained the role of CFSA and the purpose of the District of Columbia child abuse and neglect law, and addressed the specific allegations contained in the report.

Document the following information:

- Caregiver or caregiver's response to all allegations.
- Any disconcerting information that may also be contained in the social history.
- Caregiver or caregiver's demeanor and appearance.
- Note whether the interview was conducted outside the presence of another caregiver. If the interview was conducted in the presence of another individual, document the reason.

SOCIAL HISTORY

(Mother's name, father's name, or caregiver's name) is a *(age, marital status, and race)* female (or male) with *(total number of children)*: *(names/ages of children include both adults and minors)*. The father *(father's name)* of *(child's name)* resides at *(address/telephone number)*, maintains *(minimal contact, frequent visitation, etc)* with the child, and *(pays or does not pay)* child support.

Include caregivers' employment history, salary or benefits, amount, rent or mortgage amount and utilities. Include also whether the dwelling is owned, rented, subsidized, Section 8, etc.

The *(2-bedroom apartment, 3-bedroom home, etc)* was observed to be *(in disarray, disorganized, clean, cluttered, dirty, deplorable – provide further details)* and *(adequately, minimally, abundantly)* furnished. Document that the utilities were observed to be operable or inoperable at the time of the home assessment. *Describe the **sleeping arrangements**.* Worker should document the observation of a crib, bassinette, or portable playpen for any children under the age of 1.

The closets and dressers contained *(abundant, adequate, minimal, no)* **clothing** for the children *(short description)*. The **bathroom(s)** appeared *(clean, dirty, deplorable)* and *(contained or did not contain)* adequate hygiene products for the family. This worker observed *(adequate, abundant, minimal – provide further details)* supply of **food** in the refrigerator, freezer, and cupboards.

Note: worker should also include a listing of supplies or food products for infants.

The following information should also be included in the documentation:

- History of **substance abuse** – drug of choice, usage, previous treatment, clean time. If applicable, indicate that the person denied any history of substance abuse.
- History of mental health concerns
- Caregiver support system
- History of **arrests, probation, and/or domestic violence** (indicate whether the person denied any history of the above).
- Caregiver

HOUSEHOLD MEMBERS (CORE CONTACT)

Document interviews with each household member separately.

CHILDREN'S EDUCATION/DAY CARE (CORE CONTACT)

Document the following information:

- Enrollment and grade information, attendance, academic performance and any special services provided to the child.
- How the above information was obtained, including the date and source of the information.
- Contact with a daycare provider or babysitter, if applicable.

CHILDREN'S PRIMARY MEDICAL CARE (CORE CONTACT)

Document the following information:

- Name of the physician or clinic, including location of the medical practice.
- Any medical issues and history, medications, or specialized services for each child.
- The date of the last physical for each child.
- Status of immunizations for each child.

- How the above information was obtained, including the date and source of the information.

CHILDREN'S MENTAL HEALTH (CORE CONTACT)

Document the following information:

- Name of the therapist or provider and the location of the practice.
- Any mental health history and diagnoses for the caregiver and/or children.
- Level of compliance with any services provided or medications prescribed.
- Any concerns regarding the caregiver's ability (or inability) to care for the child due to mental health issues.

INVESTIGATION RELATED MEDICAL EVALUATION

Document a summary of each appointment for any child being seen at the CAPC for physical or sexual abuse. If a child was not seen for a medico-legal examination and there was a physical or sexual abuse allegation, document why this did not occur (injury no longer present, etc.).

LAW ENFORCEMENT

Document the following information:

- Contacts regarding assignment, investigations turned over to other agencies, joint investigations, or disposition determinations with the Metropolitan Police Department's Youth Investigations Division.
- Contacts regarding investigations with the Metropolitan Police Department or law enforcement in other jurisdictions.

FAMILY COURT INVOLVEMENT

OTHER CONTACTS

Document other contacts or consultations with the following groups that are relevant to the overall investigation or disposition. You do not need to include EVERY other contact that you have made on the investigation. Consider contacts involving:

- Providers
- Relatives
- Other individuals
- Office of the Attorney General and/or an Assistant Attorney General

SAFETY PLANNING

Summarize any safety planning that occurred in the investigation and any ongoing safety planning needed.

DISPOSITION

Based on the investigation conducted by this worker, it is determined that the allegation of (abuse or neglect) is (*substantiated, inconclusive, or unfounded*).

Include one or two sentences explaining the reason for each disposition.

RISK AND SERVICE PROVISION

Document one of the following recommendations for opening or not opening a case at the closure of an investigation (*see section on Disposition Decisions*):

- Unfounded or inconclusive disposition - no case opened.
- Unfounded or inconclusive disposition with high or intensive risk AND signed consent from the family - open (or re-open) case for voluntary services and transfer to In-Home and Permanency Administration.
- Substantiated disposition with safety concerns or with high or intensive risk - open (or re-open) case for supportive services and transfer to In-Home and Permanency Administration.
- Substantiated disposition without safety concerns and low or moderate risk, or substantiated disposition with a family residing outside the jurisdiction or other reason for closure at the CPS level - case opened but closed at CPS with a referral to the Collaboratives.

NOTIFICATION OF DISPOSITION

Within seven (7) days of the disposition, you are required to send a *Letter of Notification of Disposition* and *Right to Fair Hearing Form* to the individual identified as the maltreater in the report. **For your own protection and for the integrity of the investigation process, you must clearly document in FACES and in your case notes that notification was provided. Be sure to include the exact date of notification.** A copy of the letter must be put in the hard file, if applicable.

The assessment finding screen in FACES is used to document the disposition of each allegation for each maltreater, to indicate outcome (e.g., opening a case, sending to the collaborative), and to provide details regarding why the disposition was made. This information populates to the Notification of Investigation Results, which is then sent to each alleged maltreater.

To complete the screen, you must do the following:

- Complete each allegation by selecting substantiated, unfounded, or inconclusive.
- Pick a case-opening decision for each alleged perpetrator.
- Write a clear and concise statement for all allegations in the text box below the case decision to provide a reason for the disposition on each allegation for each maltreater. This information will be read by the caregiver and should inform them in a few sentences of the general reason for the finding.
- Only include the initials for the child(ren).
- Write as if you are speaking directly with the perpetrator.

CONFERENCES AND CONSULTATIONS

OFFICE OF CLINICAL PRACTICE (OCP)

Specialists within the CFSA Office of Clinical Practice (OCP) are a resource for consultation on common family dynamics involved in CPS investigations including substance abuse, domestic violence, medical care, mental health, and education. In many instances referrals to the various specialists in this administration are required (see Allegation Specific Investigation Steps) but in many more situations, the personnel in OCP are available to provide counsel and guidance in the above mentioned areas.

LEGAL

During the course of an investigation, consultation between CPS staff and CFSA's legal team safely ensures that CPS dispositions and actions are within the guidelines of federal and District rules and regulations. Consultations may include (but are not limited to) advice on testimony from CPS staff, opinions on certain steps to achieve the successful closure of a referral, and/or the propriety of requests for information and/or documentation from caregivers, lawyers and/or judges. A consultation may occur with co-located attorneys from either the Office of the Attorney General or the Office of the General Counsel.



DILIGENT SEARCH

When you have made reasonable but unsuccessful efforts to locate family members during the CPS investigation, a diligent search referral may be submitted to CFSA's Diligent Search Unit (DSU). *(For more detailed information on the DSU referral, please see the CFSA Diligent Search Policy, located on both the internet and intranet.)*

In order to comply with DSU requirements, you must follow the procedures outlined below:

- Ensure that you have documented all efforts to locate the person(s) being sought and that you have entered the results of the search in FACES, including when, where and how attempts were made to identify and/or locate the missing person(s).
- If you are still unable to locate the person being sought, consult with your supervisor to determine whether the search is complete. Your supervisor will determine whether further action is required, or whether you need to refer the case to the DSU. If your supervisor determines that the case should be referred to the DSU, complete a Diligent Search Locator Referral Form (*see Appendix...*), and submit it to your supervisor for review and signature. Once your supervisor has approved and signed the form, hand-deliver the Referral Form to the DSU supervisor or fax it to 202-727-8884.
- DSU investigations are completed within five (5) business days of receipt of the referral. At that time, you will receive a Diligent Search Referral Investigation Report that summarizes the results of the search. The Investigation Report will identify all potential leads that may assist you in locating the person being sought.
- You are expected to follow up on any leads provided by the DSU investigator.
- Once you have exhausted all leads provided by the DSU investigator, consult with your supervisor to determine whether further action is required or whether the search is complete.

OUTSIDE JURISDICTIONS

Any allegation of abuse or neglect occurring in the District must be investigated, even if the family lives in another jurisdiction. Under such circumstances, you will need to confer with the other jurisdiction's CPS unit in order to conduct a full investigation and/or complete a safety check. You may need to request a history of the family's involvement with that jurisdiction, or schedule interviews with various family members or make a home visit to the jurisdiction. At times, other jurisdictions will request information from CFSA or interviews may be conducted that the CFSA Hotline reporter will record in the form of an I&R (Information and Referral Report).

If confirmation is received that the family in question does not live in the District *and the allegations did not occur in the District*, then you should place a call to the appropriate jurisdiction and refer the allegations for investigation accordingly. Please make sure that you document such information and referrals thoroughly.

MULTI-DISCIPLINARY TEAM MEETINGS

As an employee of the Child and Family Services Agency, you are a part of the multi-disciplinary team (MDT) charged with the responsibility of investigating and prosecuting child maltreatment in the District of Columbia. You may be expected to participate in joint training with MDT members. This team includes:

- Metropolitan Police Department
- Safe Shores Children's Advocacy Center (CAC)
- Children's National Medical Center
- Office of the Attorney General- Neglect Section
- Office of the Attorney General- Juvenile Section
- United States Attorney's Office.

In order to create the most coherent and effective use of the MDT, and to facilitate communication amongst all MDT members, the following meetings are purposefully scheduled:

***Special Note:** CPS staff may at times participate in less formal meetings to discuss specific investigations.*

Pre/Post Conferences for Children's Advocacy Center (CAC) Interviews

You should plan to arrive twenty minutes prior to scheduled CAC interviews in order to participate in a facilitated pre-conference meeting. *Please be prepared to share all information that is pertinent to the current allegations, including family history with the Agency or any other information that may be useful to the MDT's involvement with the investigation.*

After CAC interviews, MDT members may decide to hold a less formalized post-conference to discuss next steps, such as needed services, potential removal of a child, or civil/criminal prosecution.

Physical Abuse Case Review

These reviews are held twice monthly and typically include participation by the supervisor or a member of CFSA's Special Abuse management team. *Please be aware that attendees may have questions or request updated information on the investigation. Communication will be facilitated by the representative from CPS management.*

Sexual abuse case review

Sexual abuse case reviews are held on a biweekly basis and typically include participation by the supervisor or a member of CFSA's Special Abuse management team. *Please be aware that attendees may have questions or request updated information on the investigation. Communication will be facilitated by the representative from CPS management.*

CASE TRANSFER STAFFING

Transfers for In-Home Services

When allegations are substantiated and the Structured Decision-Making (SDM) tool indicates a high or intensive level of risk, the case will be staffed and transferred to the In-Home and Reunification Services Administration. During this process, a case number will be generated and posted for staffing. Within 5 days of the posting, an on-going supervisor shall be assigned and the transfer staffing take place. As the CPS social worker, *please expect to attend this transfer staffing*. Additional participants will include your CPS supervisor, the assigned on-going supervisor, and the assigned on-going social worker. (With the exception of positive tox cases, cases with a low to moderate risk level are referred to one of the six Healthy Families Thriving Communities Collaborative offices provided the caregiver consents to this referral.)

The 7-day visit

CPS workers are required to see the caregiver and children within 7 business days prior to the posting of a case. The purpose of this visit is to ensure that the family remains stable and that the family be informed of the case transfer/expectations/reason for substantiation. This visit should be conducted in the home if at all possible. If it is not possible for you to see all of the children in the home, school visits may be substituted as long as all individuals in the family have been seen within the 7 business days.

Transfers Involving Removals

When a removal occurs, the Family Team Meeting shall be considered the case transfer staffing. As the CPS social worker, *please expect to attend the FTM*. At this time, the hard case file is provided to the assigned on-going worker, who is also expected to be present. If for some reason, the FTM does not occur before the initial court hearing, a regular staffing should occur within two days of the hearing. The case will be transferred at that time. Again, as the CPS social worker, *please expect to attend this transfer staffing*. Additional participants will include your CPS supervisor, the assigned on-going supervisor, and the assigned on-going social worker.

SUPERVISORY AND MANAGERIAL OVERSIGHT

ACCOUNTABILITY

CPS investigators rely upon supportive and accessible supervision to positively impact their productivity and engagement. If you have any questions regarding an investigation, including whether or not the facts presented in the investigation constitute abuse or neglect, you must seek guidance from your immediate or covering supervisor or program manager.

Supervisors shall be held accountable for the following activities:

1. Weekly review of unit data, including the number of case assignments per worker and class of cases, all of which need to be scheduled in consideration of time management for both the supervisor and the CPS social worker.
2. Review of investigations, content of FACES documentation, case planning, and assessments for safety and risk.
3. Weekly individual supervision.
4. Conferring (either via telephone or in person) with investigative staff on the same day as all initial assignments (whether immediate or regular response) to ensure that thorough and appropriate initial safety decisions have occurred and to discuss next steps.
5. Within 48 hours the following tasks must have been completed:
 - Review of FACES contacts, notes, documentation, and approval of initial safety assessment.
 - Supervision notes and further directives entered into FACES.



Program managers shall be held accountable for the following activities:

1. Weekly review of division data.
2. Case reviews, specifically trends, external issues, documentation provided by the supervisors.
3. Division planning, schedules, overtime, workforce vacancies and other personnel issues.
4. From day eighteen (18) through day thirty (30), the program manager will track the investigation daily to ensure that the case is closed on time and with the safety of the child or children intact. If there are barriers to timely closure, the program manager will immediately inform the CPS administrator in writing, including reasons for the delay and the anticipated date of closure.

WEEKLY SUPERVISION

Weekly supervision is required for each investigation.

Supervision notes must be entered in FACES after each supervision meeting. The following may be reviewed, and additional direction provided if necessary:

- interviews of victims and other children
- interviews of perpetrators
- interview with reporting source
- diligent search request and results
- records request and results
- evaluations
- safety of the child
- family risk
- appropriate service levels
- progress of investigation and report
- disposition

Weekly supervision may also address:

- Professional development
- Training
- Corrective counsel

18 DAY REVIEW

The “18-Day Review” process is a teaming opportunity held once a week for each CPS division to assist in identifying barriers and/or issues that prevent proper closure of an investigations that are 18 days or older. Team participants include CPS management (i.e., administrator, program managers, and supervisors), other CFSA management, and personnel from the CFSA General Counsel’s Office.

***Special Note:** it is the responsibility of the assigned supervisor to present every referral that has been open in their unit for 18 days or more. Social workers may also be requested to provide updates for this meeting or, at times, to attend this meeting.*

During the review meetings, team participants will first make certain that the safety of every alleged child victim has been secured, and that every child has been individually seen and interviewed. The team will further discuss additional phases of the CPS investigation process, including documentation of contacts, referrals that have been or need to be made, and/or any other issues or barriers that impact the investigation. *The review shall not be concluded without identification of the proper steps needed to complete the investigation process.*

Documentation in FACES should reflect the Agency's quality improvement efforts; therefore you **MUST** document the 18-day review, along with whatever recommendations were made and any follow-up that you completed.

“FOUR PLUS” STAFFINGS

The supervisor should take care to assess whether there is recidivism within families that are under investigation. Specifically, attention will be paid to families who have had four or more investigations. Conversation about this issue should be discussed with the program manager and determined whether any further staffing should occur regarding this family, possibly including other agency counterparts or professional stakeholders.

MANAGEMENT OF INVESTIGATION TIMEFRAMES

DC Code §4-1301.06 allows CFSA to complete a CPS investigation *no more than 30 days after receipt of the first notice of suspected abuse or neglect*. The initial contacts and safety assessment are due within 24 hours of the referral coming into the Hotline.

Supervisors are charged with monitoring the progress of investigations through the above mentioned techniques (weekly supervision, 18-Day Review, etc.). Investigations are expected to have timely initial contact, regular follow up documentation, and timely submission for closure (at least two full business days prior to the investigation reaching the 30 day mark).

In the event that there are justifiable reasons for an investigation to exceed the 30 day time frame the following procedures are to be adhered to using the “Extension Screen” in FACES.

Extension Screen Protocol

Request for the investigation extension will be used in conjunction with the 72-hour notice now provided by Supervisors (SSW) to Program Managers (PM) and the Program Administrator (PA) when referrals must exceed the 30-day time frame for closure. The Supervisor will verbally alert the Program Manager at minimum 72 hours prior to the referral going past 30 days and request approval for extension in FACES.Net. Upon authorization from the Program Manager, the Supervisor will enter the reason code for extension with supporting information into the extension comment screen. The Extension Screen will provide justification and statistical data capturing the circumstances associated with the extension.

The Extension Screen is not to be used without discussion and prior approval from a Program Manager or assigned designee and can only be requested in FACES.net at the 72 hour or 27th day of the life span of the investigation.

Important Notes:

- The Comments section is mandatory and must provide a description based upon Reason Code pick-list, to include the date and time of the Contact note authorizing the extension request and identifying next steps.
- The required field “Days of Extension” must be completed with a dummy number, which is 30, and the timeframe for the extension will be reevaluated every week to determine if more time is required for safe closure.
- Due to limited characters in the Comment section, written documentation within the Contact screens identifying the reason code, next steps, and proposed timeframes for when the referral can be completed for closure as it pertains to the extension request is required. It is understood that there are circumstances in which this cannot be determined; however, all pertinent information regarding next steps must be provided.
- It is important for ongoing documentation to be entered into the Contact screen denoting steps taken to move the referral to closure and/or the identification of new system barriers. The documentation can reflect supervision directives, 18-day review guidance, completed steps done by the Social Worker, outstanding actions, etc. The contact notes should be current and detailed with all action steps taken by the assigned Social Worker and/or staff members.
- Supervisors must be mindful that even when there is justification for an investigation to exceed the 30-day period, additional corrective action may be appropriate if the Social Worker’s documentation is not current or does not reflect the need for the investigation to exceed the 30-day timeframe.
- Investigations with an approved extension will still require regular weekly review via the 18-Day Review process as well as follow up on appropriate investigation steps. Documentation will be entered weekly, at a minimum, in FACES.net regarding the progress toward safe and timely closure.
- Only under extenuating circumstances and approval from the CPS Administrator can a 30-Day Extension be requested and approved in FACES.net after the 30-day timeframe. All requirements for documentation as referenced above must occur and be entered in the Contact screen.

Legitimate Reasons for Extension:

Unable to Identify or Locate

The Social Worker is in the process of completing all steps of Administrative Issuance CFSa-08-2, “Immediate Requirements for All CPS Investigations”, which discuss mandatory measures to identify

and locate children and families. The Social Worker may also be following other “leads” not mentioned in the above referenced AI. However, not all steps have been completed and/or the results of the investigative steps have not yet been received.

Out of Jurisdiction

A child or family currently resides or is located, due to other circumstances (visitation with family, extended vacation, etc.), outside of the DC jurisdiction. The return of the child or family and/or a response to an out of jurisdiction courtesy interview request will not occur within the 30-day period, or there is insufficient time upon their return or receipt of the requested courtesy interview assessment, to complete a safe closure. For this reason code, it is important to include all attempts made to confirm the family’s location and/or any verification that we are currently pending in the Contact section.

Uncooperative Client

The Social Worker has made reasonable efforts to engage a client who refuses access to a child, individual, home, or information pertinent to the investigation. This information is critical to child safety or the disposition of the investigation. Reasonable efforts may include police involvement, assistance of co-workers, visits on varied shifts, pre-petition custody order, etc.

Delay in Receipt of Critical Information

The Social Worker has attempted to obtain information critical to child safety and/or the disposition of the investigation. However, the receipt of this information is pending.

Links

New allegations have been linked to the investigation during the last 10 days of the 30-day timeframe and there is insufficient time to reassess child safety and appropriately disposition the new allegations of the investigation.

Law Enforcement

Aspects of joint investigations (detective assignment, CAC interview, perpetrator interview, etc.) are pending and dependent on outside sources (MPD, Safe Shores, CAPC, etc.). The pending information has a direct impact on child safety and/or disposition of the investigation.

Child Fatality

Multi-Disciplinary Team investigation information (autopsy findings, perpetrator interviews, etc.) is pending and dependent on outside sources (MPD, OCME, etc.). The pending information has a direct impact on child safety and/or disposition of the investigation.

ENHANCED GRAND ROUNDS

Grand Rounds is a monthly quality assurance meeting held by the CPS Administration to review **open** investigations that have been randomly selected from each CPS unit. The teaming panel for a Ground Rounds meeting includes various members of the Quality Assurance administration in addition to the representatives from CPS management (i.e., the administrator, program managers, and a rotating selection of two supervisors per month) as well as other agency stakeholders.

Meetings begin with a presentation by the supervisor who uses a quality assurance tool to review the status of the open referral. The panel team then provides the supervisor with feedback focused on the caliber of ongoing procedures necessary to ensure a complete and thorough investigation prior to closure. The supervisor is responsible for ensuring that any recommended actions have been taken prior to closing the investigation.

Documentation in FACES should reflect the Agency's quality improvement efforts. You **MUST** document the CPS Grand Rounds, along with whatever recommendations were made and any follow-up that you completed.

SUPERVISORY REVIEW FOR INVESTIGATION CLOSURE



In order to ensure that the investigation may be safely closed, a thorough review of the investigation activities, as well as the social worker's documentation of such in FACES, along with the safety and risk assessments is essential.

- Review the original referral and any linked referrals to refresh the concerns that brought the family to the agency's attention
 - Ensure that all concerns have been addressed in the investigation
- Review client demographics
 - Ensure that all clients have correct and consistent spelling of names and dates of birth or make notation of the reason why the spelling changed throughout the course of the investigation (new information, etc.)
- Ensure that contact screens are updated
 - Attempted or completed contacts with reporting source(s)
 - Completed and thorough FACES search
 - Completed contacts for all active clients
 - Completed medical collateral contacts
 - Completed educational and/or daycare collateral contacts
- Review of the previously completed safety assessment.
 - Determine whether any update is needed prior to closure
 - If safety concerns will persist after the investigation closure, ensure that the documentation reflects ongoing safety planning
- Review the risk assessment and approve
 - Ensure that the risk assessment accurately reflects the overall family risk

- Ensure that any necessary overrides are completed
- Review the assessment notes
- Review the disposition
 - Ensure that the documentation in the contacts and assessment notes supports the overall disposition
- Complete the case connect and approve
 - Any substantiated allegation **MUST** have a CFSA case attached to the investigation, even if it is only to support and close based on the risk level
 - Ensure that the social worker has completed the hard record, either for transfer to ongoing or for submission to closed files
 - Depending on the recommending case connect decision, justify whether a case is being opened or closed and/or whether the family is being referred to the collaborative
 - Remember that collaborative services are voluntary (even in substantiated investigations) and if a family refuses these services, an override of the overall risk level may be warranted to ensure appropriate service provision through the agency
 - Remember that without a substantiation, involvement in an agency case is voluntary for a family, regardless of risk level
 - Appropriate forms must be completed if a family consents to services (see Attachment D of the Investigations Policy)
- Review the recommendations and closure and approve

APPENDICES

- I. GLOSSARY OF TERMS
- II. KNOWLEDGE RESOURCES
- III. CPS LOGISTICAL INFORMATION
- IV. CPS PRACTICE POINTS

SECTION I: GLOSSARY OF TERMS

LEGAL DEFINITIONS

Controlled Substance: a drug or chemical substance, or immediate precursor, as set forth in Schedules I through V of § 48-901.01 et seq., which has not been prescribed by a physician.

Credible evidence: statements, documents, or other evidence that is worthy or capable of being believed. The evidence must be clearly documented in the case record.

Custodian: a person or agency, other than a caregiver or legal guardian:

- (A) to whom the legal custody of a child has been granted by the order of a court;
- (B) who is acting *in loco parentis*; or
- (C) who is a day care provider or an employee of a residential facility, in the case of the placement of an abused or neglected child.

Drug-related activity: the use, sale, distribution, or manufacture of a drug or drug paraphernalia without a legally valid license or medical prescription.

Guardian ad litem: An attorney appointed by the Superior Court of the District of Columbia to represent the child's best interest in neglect proceedings.

Mental injury: harm to a child's psychological or intellectual functioning, which may be exhibited by severe anxiety, depression, withdrawal, or outwardly aggressive behavior, or a combination of those behaviors, and which may be demonstrated by a change in behavior, emotional response, or cognition.

Neglected child:

(i) who has been abandoned or abused by his or her parent, guardian, or custodian, or whose parent, guardian, or custodian has failed to make reasonable efforts to prevent the infliction of abuse upon the child. For the purposes of this sub-subparagraph, the term "reasonable efforts" includes filing a petition for civil protection from intrafamily violence pursuant to § 16-1003;

(ii) who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his or her physical, mental, or emotional health, and the deprivation is not due to the lack of financial means of his or her parent, guardian, or custodian;

(iii) whose parent, guardian, or custodian is unable to discharge his or her responsibilities to and for the child because of incarceration, hospitalization, or other physical or mental incapacity;

(iv) whose parent, guardian, or custodian refuses or is unable to assume the responsibility for the child's care, control, or subsistence and the person or institution which is providing for the child states an intention to discontinue such care;

(v) who is in imminent danger of being abused and another child living in the same household or under the care of the same parent, guardian, or custodian has been abused;

(vi) who has received negligent treatment or maltreatment from his or her parent, guardian, or custodian;

(vii) who has resided in a hospital located in the District of Columbia for at least 10 calendar days following the birth of the child, despite a medical determination that the child is ready for discharge from the hospital, and the parent, guardian, or custodian of the child has not taken any action or made any effort to maintain a parental, guardianship, or custodial relationship or contact with the child;

(viii) who is born addicted or dependent on a controlled substance or has a significant presence of a controlled substance in his or her system at birth;

(ix) in whose body there is a controlled substance as a direct and foreseeable consequence of the acts or omissions of the child's parent, guardian, or custodian; or

(x) who is regularly exposed to illegal drug-related activity in the home

Negligent treatment (or **maltreatment**): failure to provide adequate food, clothing, shelter, or medical care, which includes medical neglect and the deprivation, is not due to the lack of financial means of his or her caregiver, guardian, or other custodian.

Physical injury: bodily harm greater than transient pain or minor temporary marks.

Preponderance of the evidence: a standard that is used in family court for adjudicating abuse and neglect petitions as well as in fair hearings. It requires more proof than the *some credible evidence* standard used in determining CPS reports. This higher standard will have to be met if the agency or family decides to take the case to court.

Sexual abuse:

- (A) engaging in, or attempting to engage in, a sexual act or sexual contact with a child;
- (B) causing or attempting to cause a child to engage in sexually explicit conduct; or
- (C) exposing a child to sexually explicit conduct.

Sexual Act: DC Code Section 16-2301 (34) and 22-3001 (8): Penetration, however slight, of the anus or vulva of another by a penis; (b) contact between the mouth and the penis, the mouth and the vulva, or the mouth and the anus; or (c) the penetration, however slight, of the anus or vulva by a hand or by any object, with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person. The emission of semen is not required for the purposes of subparagraphs (a) – (c) of this paragraph.

Sexual Contact: (DC Code Section 16-2301 (35) and 22-3001 (9) The touching with any clothed or unclothed body part or object, either directly or through the clothing, of the genitalia, anus, groin, breast inner thigh, or buttocks of any person with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person.

Sexual exploitation: a caregiver, guardian, or other custodian allows a child to engage in prostitution as defined in section 2(1) of the Control of Prostitution and Sale of Controlled Substances in Public Places Criminal Control Act of 1981, effective December 10, 1981 (D.C. Law 4-57; *D.C. Code § 22-2701.01* [now *§ 22-2701.01(3)*]), or means a caregiver, guardian, or other custodian engages a child or allows a child to engage in obscene or pornographic photography, filming, or other forms of illustrating or promoting sexual conduct as defined in section 2(5) of the District of Columbia Protection of Minors Act of 1982, effective March 9, 1983 (D.C. Law 4-173; *D.C. Code § 22-3101(5)*).

Shelter care: the temporary care of a child in physically unrestricting facilities, designated by the Division, pending a final disposition of a petition.

CHILD WELFARE PRACTICE DEFINITIONS

Caregiver refers to the adult in the household who is obligated and entitled to provide for the child's safety, well-being, routine care, and supervision. For purposes of this practice guide, the term "caregiver" has been used inclusive of the legal terms parent, guardian, and custodian.

Critical thinking: thinking which can be defined as the evaluation of the worth, accuracy, or authenticity of various hypotheses, leading to a supportable decision or direction for action.

Emergency Care facilities: facilities that provide temporary supervision and care, usually not exceeding ninety (90) calendar days and provided as a result of an individual or family crisis that includes monitoring of applicable school or work attendance and an assessment of a resident's physical, psychosocial, and educational needs.

Household: all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home.

Immediate danger: when a dangerous situation is present or likely to occur in the immediate future.

Independent living programs: programs for adolescent and young adults that provide monitored residences in apartments or single dwelling units and serviced around preparing the adolescent or young adult to live successfully, on his or her own, in the community. Residents can include teen mothers and their children.

Impending Danger: threats to child safety that is not obvious or occurring at the onset of CPS intervention or in a present context. Such danger is identified and understood after full evaluation and understanding of the individual and/or family conditions and/or family functioning. In other words impending danger refers to a family situation in which a child is not in immediate danger but there yet exists a general state of danger because of what is understood to be happening within his or her family. Without a safety intervention, there is reasonable cause to believe the impending danger will lead to severe harm of the child.

Licensed or temporarily licensed Foster homes/kinship homes

- “Temporary licensed” -- Permission has been granted to operate a foster home for a temporary period via the issuance of a license that is granted for no more than 120 days upon interest of a kin member regarding a related child in placement in order to complete training and other licensing requirements.
- “Licensed” -- Permission has been granted to an applicant to operate a foster home via the issuance of a license.

Protective Capacities: personal and behavioral, cognitive and emotional characteristics of care giving that specifically and directly can be associated with being protective of one’s young. These protective capacities contribute to vigilant child protection and apply specifically to the adult who lives with the child and is responsible for the primary care of the child.

Reasonable Efforts: activities and attempts to assess and analyze impending danger and to seek people, resources and alternative methods for in home safety plans that prevent child placement or that allow for a child to be reunified with his or her family.

Risk: the likelihood of maltreatment in the future.

Runaway shelters: short-term facilities that house minor children who have absconded or otherwise departed the parental or legal guardian home, contrary to the wishes of the parent or guardian. Runaway shelters provide safety, twenty-four (24) hour supervision, physical and emotional

nourishment and counseling to help resolve the difficulties between the children and their parent(s), so the children can return to the parental home.

Safety Plan: a written arrangement between caregivers and CPS that establishes how impending danger threats will be managed. The safety plan is implemented and active as long as impending danger threats exist and caregiver protective capacities are insufficient to assure a child is protected. The safety plan specifies what impending dangers exist, how the impending danger will be managed using identified safety services; who will participate in those safety services; under what circumstances and agreements and in accordance with what specification of time requirements, availability, accessibility and suitability of those involved. The safety plan is designed along a continuum of least-to-most intrusive intervention: in-home safety options, a combination of in-home and out-of-home safety options, and out-of-home safety options.

A “**vulnerable child**” means a child who is unable to protect him or herself. This includes a child who is dependent on others for sustenance and protection. Evaluating information about **child vulnerability** is crucial when trying to determine if a child is vulnerable to an identified safety threat. Vulnerability is judged according to the child’s physical and emotional development, ability to communicate needs, mobility, size and level of dependence.

Youth group homes : facilities that provide twenty-four (24) hour care for residents. Youth group homes maintain staff to meet the physical, emotional and developmental needs of their residents and provide supervision, guidance and recreation to their residents.

Youth shelters: facilities that provide temporary residential placement for alleged or adjudicated juvenile offenders prior to disposition by a court.

SECTION II: KNOWLEDGE RESOURCES

1. Safety Assessment Criteria
2. Signs of Developmental Delays
3. OCAP Domestic Violence Services/CFSA & SAFE MOA
4. Domestic Violence Resources and Service Providers
5. How long do Drugs stay in Your System?

SAFETY ASSESSMENT CRITERIA

Signs of Present Danger

- A child has received serious physical harm or injury that appears to be inflicted.
- The child has physical injuries resulting from use of instruments (e.g. cigarette burns, hot water, belts, sticks) to inflict severe pain or injuries due to dangerous acts (e.g., choking, shaking of an infant, or cruelty).
- The child has a serious physical injury and the caregiver has given an explanation that is inconsistent or insufficient.
- The child has special needs, behaviors or medical concerns that are not being met or managed and failure to do so may result in immediate danger of serious harm to the child.
- It appears that caregiver has not, cannot, or will not protect the child from potential serious harm, including harm from other persons having familial access to the child; or, caregiver overtly rejects any intervention that is necessary to prevent or eliminate immediate danger of serious harm to the child.
- Caregiver or other person having access to the child has made a credible threat or other person expresses a credible belief that caregiver's actions may result in serious harm to a child.
- The behavior of any member of the household or other person having access to the child is violent and/or out of control, and suggests that the child may be or is presently in immediate danger of serious harm.
- Any member of the household or other person having access to the child describes actions or acts toward the child in predominantly or extremely negative terms and/or has extremely unrealistic expectations of the child that would suggest the child may be in immediate danger of serious harm.
- Drug and/or alcohol use by any member of the household or other person having access to the child suggests that the child may be in immediate danger of serious harm.
- Behavior(s) of any member of the household or any person having access to the child that is symptomatic of some disability or a mental or physical illness and the child may be in immediate danger of serious harm.
- Caregiver appears unwilling or unable to meet the child's immediate needs for sufficient supervision, food, clothing, and/or shelter that would otherwise protect child from immediate danger of serious harm.
- Caregiver appears unwilling or unable to meet the child's immediate physical or mental health needs and failure to do so may result in the child being in immediate danger of serious harm.
- Household environmental hazards suggest that the child may be in immediate danger of serious harm.
- Acts of domestic violence (e.g. family violence or batterer violence) suggest a child may be immediate danger of serious harm.
- Child sexual abuse/sexual exploitation is suspected, and circumstances suggest that child may be in immediate danger of serious harm.
- Child is exposed to criminal activities in the household (e.g. the manufacturing, distribution, drug trafficking or sale of illegal drugs) and the child may be in immediate danger due to the exposure to these activities.
- Caregiver has previously had parental rights terminated as a result of abuse or neglect and/or has failed to benefit from any previous services related to child safety issues, and/ or has had children removed from his/her care due to abuse/neglect.
- There is reason to believe the child is in immediate danger of serious harm and the family refuses the Agency access to the child, or the child's whereabouts cannot be ascertained, or there is reason to believe the family will flee.
- A paramour is the alleged or indicated perpetrator of physical abuse or sexual abuse.
- Child is fearful of caregiver(s), other family members, or other people living in or having access to the home.

Protective Capacities of the Caregiver

- Defers his/her own needs in order to meet the child(ren)'s needs.
- Displays a desire/capability to prevent future harm to the child(ren).
- Accepts/demonstrates the responsibility and skills to nurture and provide for the basic needs of the child(ren).
- Demonstrates the motivation and physical ability to intervene and chooses to intervene to protect the child(ren) from others.
- Demonstrates ability/motivation to control negative impulses and unsafe behavior.
- Demonstrates healthy attachment to the child(ren).
- Perceives the child(ren) in predominantly positive or realistic terms.
- Facilitates CPS access to the child(ren).
- Receptive to intervention.
- Readily identifies actions necessary to protect the child(ren) from serious harm.
- Demonstrates readiness to change related to child safety.
- Extended family members or social supports are readily accessible and capable of preventing future harm to the child(ren).
- Provides resources necessary to assure the child(ren)'s safety.
- Possesses skills necessary to meet the child(ren)'s safety needs and chooses to do so.

Child Vulnerability Factors

The vulnerability factors of children are identified on the safety assessment:

- 0 - 5 years.
- Medically fragile.
- Physically handicapped or disabled.
- Developmentally disabled.
- Emotionally disturbed.
- Has a serious illness or health problem.
- Unable to communicate.
- Prone to inconsolable crying.
- Sustained a serious injury requiring immediate medical attention.
- Exhibits FAE/FAS, positive toxicity, or HIV.
- Sexually abused.
- Malnourished and underweight.
- Sexually provocative, juvenile delinquent or significant behavioral problems.
- No Child Vulnerability Factors.

SIGNS OF DEVELOPMENTAL DELAYS

Note: this list is not comprehensive! Any single concern may not necessarily indicate a delay. Keep in mind when assessing a child's development that there is a range of "normal" within each stage. You must schedule an assessment and/or testing for any child whom you suspect has a developmental lag, regardless of the child's age. **Reminder:** for every investigation that is substantiated involving a child age 0-3, you must refer the child to OCP within 72 hours of the investigation decision.

AGE	WARNING SIGNS OF DEVELOPMENTAL DELAYS
Newborn-six months	<ul style="list-style-type: none"> • Does not appear startled or does not turn head towards a loud noise. • Feeding trouble. • Clenching of fists after 3 months. • Stiff in trunk, arms, legs. • Floppy like a rag doll when not sleeping. • Does not hold head up when lying on stomach by 4 months. • Not rolling over by 6 months. • Not exploring own hands, feet, mouth. • Not starting to grasp at objects within reach by 6 months.
6-12 months	<ul style="list-style-type: none"> • Not smiling/laughing by 6 months. • Not making eye contact by 6 months. • Not sitting up without support by 7 months. • Not using baby talk by 9 months. • Not feeding self with fingers by 12 months. • Showing little or no anxiety when being separated from caregiver.
12-24 months	<ul style="list-style-type: none"> • Not making eye contact by 12 months. • Not responding when name is called. • Not walking easily by 18 months. • No pointing or responding to pointing. • Rocking, hand slapping, head banging.
2-3 years	<ul style="list-style-type: none"> • Not using 2 word phrases by 2 years. • Not able to name 6 body parts by 3 years. • Not feeding self by 3 years. • Excessive nightmares and/or routinely disturbed sleep.
3-6 years	<ul style="list-style-type: none"> • Unable to run, jump, and/or climb easily by 4 years. • Not speaking in full sentences by 5 years. • Unable to dress independently by 5 years. • Violent towards animals or people. • Extremely fearful. • Trouble controlling bladder or bowels while awake.

6-12 years	<ul style="list-style-type: none"> • Failing grades in school. • No friends, isolated. • Sudden change in behavior. • Changes in eating and sleeping patterns. • Enuresis (bedwetting) or Encopresis (uncontrolled bowels). • Destructive or self-destructive behavior.
12-19 years	<ul style="list-style-type: none"> • Sudden change of behavior. • Withdrawn, socially isolated, or sullen. • Abusing alcohol or drugs. • Practicing unsafe sex. • Highly conflicted relationships with family or peers. • Destructive or self-destructive behavior.
19-21 years	<ul style="list-style-type: none"> • Socially inappropriate behavior. • Abusing alcohol or drugs. Practicing unsafe sex. • Highly conflicted relationships with family or peers. • History of involvement with the police. • Failure to take medical or financial responsibility.

OCAP DOMESTIC VIOLENCE SERVICES

CFSA & SAFE MEMORANDUM OF AGREEMENT OVERVIEW

OCAP-INNOVATIVE FAMILY SUPPORT SERVICES ADMINISTRATION

Background

The District of Columbia's Child and Family Services Agency (CFSA) and Survivors and Advocates for Empowerment, Inc. (SAFE) has entered into a new Memorandum of Agreement for the provision of domestic violence services, *effective June 1, 2010*. This partnership provides on-call crisis intervention, advocacy and support services to CFSA clients through the **On Call Advocacy Program (OCAP)**, 24 hours, 7 days a week.

Population Served

CPS, In-home and Out-of-home CFSA social workers and contracted, private provider social workers may refer clients:

- Identified as a victim of domestic violence
- Voluntarily agree to receive services through OCAP
- Residing in the Washington, DC Metropolitan area

SAFE will provide services to:

- Female and male victims
- Lesbian, Gay, Bi-sexual, Transgendered or Questioning (LGBTQ) victims
- Youth 12 and older (youth under the age of 15 must have parental consent)

Services

- Legal information and protection orders
- Assistance writing and filing Civil Protection Orders and motions for criminal contempt
- Information about family law, criminal law and child support
- Safety planning assistance
- Public benefits referrals
- Emergency financial assistance
- Emergency cell phones
- Court accompaniment for victims
- Emotional support
- Assistance with any other portion of the court or social services system
- Access to immediate emergency shelter
- Access to the after hours emergency temporary protection order process
- Assistance with Crime Victim's Compensation Program (CVCP) applications
- Transportation Assistance and baby/children supplies as needed
- Assignment to a SAFE Advocate at the court for the duration of their case

Hours of Operation

SAFE Advocates are available 24 hours, 7 days a week, including federal and local holidays.

- SAFE Advocates will contact social workers within 5 minutes of a referral or in person within one(1) hour

Referral Process

Social workers may refer clients directly by calling SAFE's hotline at **1-800-407-5048** and identifying themselves as a CFSA social worker or a CFSA contracted private agency social worker.

AFE will notify CFSA's Domestic Violence Specialist of all referred clients. CFSA's Domestic Violence Specialist will collaborate with SAFE and the assigned social worker on all clients assessed by SAFE to be at high risk of serious assault, re-assault or homicide. CFSA's Domestic Violence Specialist will provide consultation and support to social workers on low and moderate risk cases, as requested.

DOMESTIC VIOLENCE RESOURCES AND SERVICE PROVIDERS

AYUDA Ayuda provides multilingual legal and social services for low-income immigrants in the areas of immigration, human trafficking, domestic violence and sexual assault.	202-387-4848
CRIME VICTIM'S COMPENSATION PROGRAM	202-879-4216
DASH (District Alliance for Safe Housing Inc.) http://www.dashdc.org/hrc.html DASH's Housing Resource Center at the Lighthouse Center for Healing in Ft. Totten is open for survivors to obtain housing counseling and support. Current affordable housing listings, information about housing programs and computers with internet access are available for conducting individual housing searches.	202-462-3274 Housing Resource Center 202-742-1728.
DC RAPE CRISIS CENTER http://www.dcrcc.org/ Support and Counseling for <u>Adult Sexual Assault Survivors</u> <u>Adult Survivors of Child Sexual Abuse</u> <u>Children</u> <u>Gay, Lesbian, Bisexual, Transgender and Queer</u> <u>Deaf Survivors</u> <u>Male Survivors</u>	202-333-RAPE
FAMILY CRISIS CENTER OF PRINCE GEORGES COUNTY http://www.familycrisiscenter-pgco.org/	24 HOUR HOTLINE: 301.731.1203.

Provides a 24-hour hotline and access to their SAFE PASSAGE PROGRAM EMERGENCY SAFE HOUSE , which gives victims who are fleeing violence in their homes, a safe, clean and therapeutic environment.	
<u>National Domestic Violence Hotline</u>	1.800.799.SAFE
HOUSE OF RUTH- Domestic Violence Hotline	202) 667-7001 x217
MY SISTER'S PLACE 24-hour Hotline and Emergency Housing	(202) 529-5991
WEAVE WEAVE works closely with adult and teen survivors of relationship violence and abuse, providing an innovative range of legal , counseling , and educational services that leads survivors to utilize their inner and community resources, to achieve safety for themselves and their children and to live empowered lives.	phone: 202.452.9550 fax: 202.452.8255 / e-mail: info@weaveincorp.org

Domestic Violence Resources

The DC Coalition Against Domestic Violence provides an extensive listing of domestic violence resources in DC, Maryland and Virginia. Go to dccadv.org

Drugs and Their Effects

According to the *First Citywide Comprehensive Substance Abuse Strategy for the District of Columbia*,³ which was published in 2003, the use of illicit drugs in the District was **52% higher than that of the nation**. Equally disturbing was the rate of drug addiction (8.9%), which was almost double the national rate (4.7%). This pervasive use of drugs in the District continues to influence and be influenced by homelessness, unemployment, mental illness, and crime. (Almost 60% of male teenagers who are arrested in the District are tested positive for illegal drug use.)

Misuse/abuse of drugs is an issue that immediately impacts children, youth, and families served by CFSA. Research studies confirm that children whose parents or caregivers are misusing drugs (or are addicted to drugs) perform poorly in school, often suffer from emotional and/or psychological problems, present with behavioral problems (e.g., truancy, delinquency, etc.), and most importantly for the CPS investigator, are more likely to suffer child abuse and neglect at the hands of the drug-using caregiver.

When you assess a family and/or the home for safety and risk, it is important that you are familiar with the names, effects, paraphernalia, and even withdrawal symptoms related to the use of the ten most common illicit drugs:

- **cocaine** (coke, snow, blow)
- **crack cocaine** (crack, rock, freebase)
- **ecstasy** (clarity, lover's speed)
- **heroin** (smack, junk, brown sugar, horse)
- **LSD** (acid, white lightening, blue heaven, sugar)
- **marijuana** (pot, weed, mary jane, dope, ganja)
- **methamphetamine** (crank, ice, crystal meth, speed)
- **opium** (paregoric, dover's powder)
- **PCP** (angel dust, hog, loveboat)

³

Available on the District's Addiction Prevention and Recovery Administration (APRA) website at http://doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/apr/pdf/dcstrategy2003_10_15_03.pdf&group=1787&open

- **psilocybin** (magic mushrooms, 'shrooms)

While the above-cited drugs may be the “most popular”, there are still many others that are commonly used and equally as dangerous to the users and to any children who are exposed to their use, particularly in utero. Additional abuse might include over-the-counter drugs, including cough syrups and inhalants, or more serious prescription drugs such as oxycontin or oxycodone (see *Prescription Drug Abuse* section below).

The following table gives a general description of the top ten drugs, their clinical names, effects, associated paraphernalia, and withdrawal symptoms.

Note: this list is not exhaustive! If you have any suspicion of misuse of any drugs by your clients, including youth, caregivers, and/or resource parents, you should consult with the Agency's Office of Clinical Practice.

TEN MOST COMMONLY USED ILLICIT DRUGS

COCAINE (cocaine hydrochloride)				
How it looks	How it's ingested	Possible Effects ("positive"& negative)	Withdrawal Symptoms	Federal Class
White crystalline powder (extracted from leaves of the coca plant)	Inhalation (snorting) Injection Paraphernalia: razor blades (for cutting), small mirrors (surface for cutting and	<ul style="list-style-type: none"> • Stimulates central nervous system • Euphoric sense of happiness • Extra energy • Amplified sexual interest • Suppresses appetite • Relief of high altitude sickness • Increased blood pressure and heart rate • Restlessness • Anxiety • Paranoia • Aggressive behavior 	<ul style="list-style-type: none"> • Irritability • Depression • Craving for more • Fatigue 	Schedule II i.e., drug has high potential for abuse, is or can be used medically, and can be highly addictive

	<p>laying out lines), special thin pipes for snorting (or plastic straws, rolled up currency, etc.)</p> <p>syringes and needles (when injected)</p>	<ul style="list-style-type: none"> • Seizures • Twitching • Sexual dysfunction • Perforated nasal septum • Dilated pupils • Dependence and addiction <p>Effects may last anywhere from 15 minutes to several hours depending on purity and amount taken.</p>		
<p style="text-align: center;">CRACK COCAINE</p> <p style="text-align: center;">(COCAINE HYDROCHLORIDE)</p>				
How it looks	How it's ingested	Possible Effects ("positive"& negative)	Withdrawal Symptoms	Federal Class
<p>White or tan pellets</p> <p>Crystalline chips, chunks, or soap-like rocks</p> <p>(processed from powdered cocaine using water and ammonia or sodium bicarbonate, i.e., baking soda)</p>	<p>Smoking</p> <p>Inhalation (of fumes)</p> <p>PARAPHERNALIA:</p> <p>glass pipes fitted with one or more mesh screens</p>	<ul style="list-style-type: none"> • Stimulates central nervous system • Euphoric sense of happiness • Extra energy • Amplified sexual interest • Suppresses appetite • Relief of high altitude sickness • Increased blood pressure and heart rate • Restlessness • Anxiety • Paranoia • Aggressive behavior • Seizures • Twitching • Sexual dysfunction • Dilated pupils • Dependence and addiction <p>Effects last from 5 to 10 minutes.</p>	<ul style="list-style-type: none"> • Irritability • Depression • Craving for more • Fatigue 	<p>Schedule II</p> <p>i.e., drug has high potential for abuse, is or can be used medically, and can be highly addictive</p>

ECSTASY (methylenedioxy-methamphetamine, MDMA)				
How it looks	How it's ingested	Possible Effects ("positive"& negative)	Withdrawal Symptoms	Federal Class
<p>Tablet form</p> <p>White crystalline powder</p> <p>Candy (e.g., Skittles' packaging is opened and candy is replaced with tablets, or Tootsie Rolls are melted, mixed with the drug, then rolled back up and sold)</p>	<p>Orally (most common)</p> <p>Rectally ("shafting")</p> <p>Inhalation (tablets are crushed into powder form)</p> <p>Injection</p> <p>Paraphernalia:</p> <p>pacifiers or mouth guards (to alleviate jaw clenching or teeth grinding)</p> <p>chest rubs or nasal inhalers (to enhance effects)</p> <p>NOTE: research has connected the ingestion of ecstasy during pregnancy with certain birth defects</p>	<ul style="list-style-type: none"> • Mild hallucinations • Transcendental and/or spiritual experiences • Increased tactile sensitivity • Empathic feelings • Impaired memory and/or learning capacity • Hyperthermia (high fever) • Involuntary jaw clenching or teeth grinding (possibly with permanent damage) • Cardiac and/or liver toxicity • Renal (kidney) failure • Elevated pulse • Nausea • Blurred vision • Thirst • Hyponatremia (low sodium levels in the blood) • Inability to urinate <p>Effects usually last 3-4 hours but may last up to 24 hours, with some effects lasting up to 14 days.</p>	<ul style="list-style-type: none"> • Panic attacks • Lack of sleep • Anxiety • Depression • Psychosis • Paranoia • Dis-associative disorders 	<p>SCHEDULE I</p> <p>i.e., drug has a high potential for abuse, does not have a current medical use in the U.S., and there is no current medically safe purpose for its use</p>
HEROIN (diacetylmorphine – opium derivative)				

How it looks	How it's ingested	Possible Effects ("positive"& negative)	Withdrawal Symptoms	Federal Class
White or brown powder Tar-like substance	Injection (usually directly into the veins but also into muscle and skin) Smoking (snort) Inhalation Dissolved in nose drops Paraphernalia: syringes needles tourniquets (rubber hoses) eyedroppers pipes	<ul style="list-style-type: none"> • Pain relief • Euphoria • Enhanced sexual pleasure • Depression of central nervous and respiratory systems • Feelings of heaviness in the limbs • Dryness of the mouth • Slow or slurred speech • Drooping eyelids • Impaired night vision • Clogging of blood vessels • Dependence and addiction <p>Effects may last 3 to 4 hours.</p>	<ul style="list-style-type: none"> • Craving for more • Restlessness • Muscle and/or bone pain • Insomnia • Diarrhea • Vomiting • Cold flashes • Involuntary kicking of the legs 	Schedule I i.e., drug has a high potential for abuse, does not have a current medical use in the U.S., and there is no current medically safe purpose for its use
<p style="text-align: center;">LSD</p> <p style="text-align: center;">(lysergic acid diethylamide)</p>				
How it looks	How it's ingested	Possible Effects ("positive"& negative)	Withdrawal Symptoms	Federal Class
Colored tablets	Orally	<ul style="list-style-type: none"> • Psychedelic hallucinations • Transcendental and/or spiritual experiences • Altered states of perception and feeling 	LSD is not an addictive drug. The following are consistent with "after	Schedule I i.e., drug has

Blotter paper	Eye drops	<ul style="list-style-type: none"> • Dry mouth • Tremors • Increased blood pressure • Loss of appetite • Dilated pupils • Nausea • Sweating • Impaired judgment (being impervious to real dangers) • Acute anxiety • Fear • Depression • Psychosis • Panic attacks 	effects” of usage.	a high potential for abuse, does not have a current medical use in the U.S., and there is no current medically safe purpose for its use
Clear liquid	Paraphernalia:		<ul style="list-style-type: none"> • Persistent perception disorder (or “flash backs” which can occur days, weeks or even a year after use) • Persistent mental disorders (psychotic episodes) • Acute anxiety • Fear • Depression • Panic attacks 	
Thin blocks of gelatin	generally, there are no paraphernalia involved with LSD use, but blotter paper, sugar cubes, and/or gelatin might be signs of LSD	Effects may last up to 12 hours, with flash backs occurring days, weeks, or even a year later.		

MARIJUANA

(cannabis)

How it looks	How it's ingested	Possible Effects (“positive” & negative)	Withdrawal Symptoms	Federal Class
<p>Dried brown, green or grayish colored herbs (e.g., may look like parsley or oregano)</p> <p>Five-leafed plant, buds, sometimes</p>	<p>Smoking (active ingredient is delta-9-tetrahydrocannabinol)</p> <p>Oral ingestion through food (e.g., leaves or buds added to brownies or cookies)</p>	<ul style="list-style-type: none"> • Heightened sense of perception • Sense of relaxation • Sense of happiness and well-being • Mild hallucinations • Amelioration of nausea • Spiritual experiences • Increased appetite • Altered sense of time • Anxiety • Paranoia • Dry mouth • Short-term memory loss • Impaired coordination and/or balance 	<ul style="list-style-type: none"> • Irritability • Depression • Headaches • Restlessness • Insomnia • Decreased appetite • Cravings for more 	<p>Schedule I</p> <p>Note: this drug is not federally approved for medical use even though it has been legalized by some states. It is still classified as illegal.</p>

stems, and seeds		<ul style="list-style-type: none"> Increased heart rate <p>Effects may last for 3 to 4 hours.</p>		
Hand-rolled cigarettes	Paraphernalia: rolling papers, pipes, and pipe accessories			
METHAMPHETAMINE (methamphetamine hydrochloride)				
How it looks	How it's ingested	Possible Effects ("positive"& negative)	Withdrawal Symptoms	Federal Class
White powder	Orally			
Tablets	Injection	<ul style="list-style-type: none"> Euphoria Excitement Alertness Increased sexual interest Self-confidence Dry mouth Headache Dilated pupils Thinning of the skin High fever Acne Anxiety Difficulty urinating Anorexia Blurred vision Obsessive behavior (repetitive cleaning, assembling and disassembling objects, etc.) Dependence and addiction 	<ul style="list-style-type: none"> Excessive sleeping and/or eating Depression Anxiety Craving for more Aches and pains Unstable heart conditions 	Schedule II
Paraffin-like rocks	Paraphernalia: syringes needles tourniquets (rubber hoses) EYEDROPPERS PIPES Note: funnels, flasks, tubing, thermometers and cooking equipment may	Effects may last from 2 to 20 hours.		i.e., drug has high potential for abuse, is or can be used medically, and can be highly addictive

	be used to manufacture this drug.			
OPIUM (lachryma papaveris)				
How it looks	How it's ingested	Possible Effects ("positive"& negative)	Withdrawal Symptoms	Federal Class
Dark brown chunks Powder Tincture	Inhalation (of vapors or fumes) Oral ingestion Injected Paraphernalia: special opium pipes with opium lamp	<ul style="list-style-type: none"> Relief of pain Curative for diarrhea Euphoria Induces sleep Sense of courage Feelings of ecstasy Enhances sexual sensations Cough suppressant Respiratory ailments Dependence and addiction Effects may last up to 12 hours.	<ul style="list-style-type: none"> Nightmares Hallucinations Nausea Sweating Cramps Vomiting Diarrhea Depression Anxiety Insomnia Mood swings 	Schedule II i.e., drug has high potential for abuse, is or can be used medically, and can be highly addictive
PCP (phencyclidine)				
How it looks	How it's ingested	Possible Effects ("positive"& negative)	Withdrawal Symptoms	Federal Class
Liquid (for spraying on tobacco or cannabis and then	Orally Smoking	<ul style="list-style-type: none"> Relief of pain Euphoria Hallucinations Trance-like states Disassociation ("out-of-body" experiences) Increased heart rate 	<ul style="list-style-type: none"> Diarrhea Chills Tremor Muscle rigidity Convulsions Coma Psychosis Violent 	Schedule II i.e., drug has high potential for abuse, is or

smoked)		<ul style="list-style-type: none"> • Catatonia • Mania • Delirium • Slurred speech • Unsteady gait • Dilated pupils 	behavior	can be used medically, and can be highly addictive
White crystalline powder	Injection			
Pills	Paraphernalia: special opium pipes with opium lamp	Effects last only a few hours.		
Capsules				
<p style="text-align: center;">PSILOCYBIN</p> <p style="text-align: center;">(4-phosphorylhydroxy-N-N-dimethyltryptamine)</p>				
How it looks	How it's ingested	Possible Effects ("positive"& negative)	Withdrawal Symptoms	Federal Class
Mushrooms (fresh or dried)	Chewed and/or Swallowed	<ul style="list-style-type: none"> • Hallucinations • Visions • Mystical experiences • Revelations • Happiness • Relief from obsessive-compulsive disorder (OCD) • Relief from cluster headaches • Sensorial disturbances • Distress • Nervousness • Twitching • Dilated pupils • Paranoia (fears of insanity, death, or losing control) <p>Effects may last 3 to 7 hours.</p>	<p>Like LSD, psilocybin is not addictive. The following after-effects are not the same as regular "withdrawal" symptoms from addictive drugs.</p> <ul style="list-style-type: none"> • Persistent perception disorder • Psychological withdrawal 	<p>Schedule I</p> <p>Note: this drug is not federally approved for medical use even though some clinical research has proven positive use. It is not legal.</p>

PRESCRIPTION DRUG ABUSE

In general, prescription drugs are legally obtained by adults for legitimate reasons but a growing number of teens are frequently abusing these otherwise legal drugs. According

to the federal Office of National Drug Control Policy, abuse of prescription drugs (i.e., tranquilizers, sedatives, pain relievers, stimulants) is only second to the abuse of marijuana in the United States. All CPS investigators should be familiar with different types of prescription drugs, their effects, and possible withdrawal symptoms.

There are three basic types of prescription drugs:

- opioids
- central nervous system (CNS) depressants
- stimulants

COMMONLY ABUSED PRESCRIPTION DRUGS				
Name	Type	Possible Effects ("positive" & negative)	Withdrawal Symptoms	Federal Class
Brevital (methohexital) Surital (thiamylal) Seconal (secobarbital)	CNS depressant - Barbiturates	<ul style="list-style-type: none"> • Mild euphoria • Sleep induction • Impaired thinking and/or coordination • Release of inhibition • Slurred speech Effects may last 4 to 16 hours	<ul style="list-style-type: none"> ▪ Irritability ▪ Fainting ▪ Nervousness ▪ Convulsions ▪ Nausea 	Schedule II (see table above)
Xanax (alprazolam) Valium (diazepam) Ativan	CNS depressant - Benzodiazepine	<ul style="list-style-type: none"> • Reduces anxiety • Anti-depressant • Muscle relaxants • Reduction of irritability and/or excitement • Induces sleep • Anti-convulsants Effects may last 6 to 12 hours.	<ul style="list-style-type: none"> • Anxiety • Irritability • Insomnia • Muscle spasms • Dizziness • Paranoia • Tremor • Dis-association • Suicide 	Schedule IV i.e., drug has low potential for abuse, is or can be used medically, and is minimally addictive

(Lorazepam)				
Restoril (temazepam)				
Codeine (methyl- morphine) Oxycodone (thebaine) Morphine (opiate analgesic)	Opioid	<ul style="list-style-type: none"> • Euphoria • Relief of pain (severe and/or chronic) • Cough suppressant • Constipation • Loss of appetite • Fatigue • Nausea <p>Effects may last 6 to 12 hours.</p>	<ul style="list-style-type: none"> • Watery eyes • Diarrhea • Insomnia • Headaches • Involuntary leg kicking • Depression • Paranoia • Back pain 	<p>Schedule II</p> <p>(see table above)</p>
Dexedrine (dextro- amphetamine sulfate) Adderall XR (amphetamine)	<p>Stimulant -</p> <p>Dextro- amphetamine</p>	<ul style="list-style-type: none"> • Relief of narcolepsy • Relief of attention deficit disorder (with hyperactivity) • Increased blood pressure • Tremor • Headache <p>Effects last 24 hours.</p>	<ul style="list-style-type: none"> • Fatigue • Irritability • Depression • Violence • Disturbed sleep 	<p>Schedule II</p> <p>(see table above)</p>

ALCOHOL ABUSE

Although research supports moderate use of alcohol for some health benefits, alcohol abuse or dependence is fraught with medical complications. Since it is legal and readily accessible, it is one of the most dangerously addictive available drugs in society. In fact, dependence on alcohol is the primary source of addiction in the District of Columbia.⁴ It also has a much higher percentage of abuse in the District than the national average (14% compared to 9.2%). Again, like other drugs, use of alcohol during pregnancy is particularly dangerous and one of the most preventable causes of birth defects.

As a CPS investigator, it is important that you not only know the signs of alcohol abuse, but that you also recognize that there are now psychiatric implications of alcohol abuse currently listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) under *Substance Abuse Disorders*. Lastly, it is important that you recognize the dramatic influence of alcohol abuse on youth. As reported in 2009 by the District's Addiction Prevention and Rehabilitation Administration (APRA), "approximately one in four high school students took their first drink of alcohol before age 13."⁵ These youth will likely continue drinking despite formidable consequences, including fatal automobile accidents.

⁴ First Citywide Comprehensive Substance Abuse Strategy for the District of Columbia; see Footnote #1 above.

⁵ Youth and Drugs: The Case for Infrastructure and Targeted Strategies in the Nation's Capitol (APRA, 2009)

ALCOHOL (ethanol C ₂ H ₅ OH)				
Basic Types	Source Alcohol %	Possible Effects ("positive" & negative)	Withdrawal Symptoms	Federal Class
Beer	Fermented grains 3-6 %	<ul style="list-style-type: none"> – Mild euphoria – Increased longevity (for older, moderate drinkers - ages 48+) 		Non-applicable Only drugs that are not openly legal for purchase by adults are classified.
Wine	Fermented fruits 11-14% Note: dessert wines or ...	<ul style="list-style-type: none"> – Lowered coronary heart disease (35% in moderate drinkers) – Lowered inhibitions – Loss of balance and/or coordination 	<ul style="list-style-type: none"> – Tremors – Anxiety – Panic attacks – Hallucination – Delusions – Paranoia – Nausea – Vomiting – Elevated heart rate – Convulsions – Seizures – Death (if untreated) 	
Liquor (e.g., whiskey, vodka, rum, tequila, gin, etc.)	Distillation of fermented grains (wheat, barley, rye), corn, potatoes, agave, sugarcane, juniper berries 40-50 %	<ul style="list-style-type: none"> – Impaired judgment (inappropriate behavior) – Slurred speech – Delayed reflexes – Irritability – Dehydration – Vomiting – Unconsciousness – Liver disease 		

TOBACCO USE

Addiction to nicotine (the active ingredient in tobacco) is now a widely-recognized problem for smokers, in addition to the health warnings that smoking causes cancer. This information appears to have impacted District teens who markedly decreased their use of tobacco between 2003 and 2009.⁶ Nonetheless, District teens continue to buy and smoke cigarettes.

Research does indicate that nicotine has some relaxation effects on the body, including mild pain relief and increasing positive emotions. Nicotine stays in the body for about two hours, *if only one cigarette is smoked*. The cumulative effect, however, will last for six

⁶ *Youth and Drugs: The Case for Infrastructure and Targeted Strategies in the Nation's Capitol* (APRA, 2009)

to eight hours, and will increase the desire for more. When withdrawing from nicotine addiction, the American Heart Association reports that one or more the following symptoms will occur:

- irritability
- impatience
- hostility
- anxiety
- depressed mood
- difficulty concentrating
- restlessness
- decreased heart rate
- Increased appetite or weight gain

How Long Do Drugs Stay in Your System?

Please Note: The detection windows depend upon multiple factors - drug class, amount and frequency of use, metabolic rate, and urine pH.

Substance	Urine	Hair	Blood / Oral Fluid
<u>Alcohol</u>	6–24 hours	up to 90 days	12–24 hours
<u>Amphetamines</u> (except meth)	1 to 3 days	up to 90 days	12 hours
<u>Methamphetamine</u>	3 to 5 days	up to 90 days	1–3 days
<u>MDMA (Ecstasy)</u>	24 hours	up to 90 days	25 hours
<u>Barbiturates</u> (except phenobarbital)	1 day	up to 90 days	1 to 2 days
<u>Phenobarbital</u>	2 to 3 weeks	up to 90 days	4 to 7 days
<u>Benzodiazepines</u>	Therapeutic use: up to 7 days. Chronic use (over	up to 90	6 to 48 hours

	one year): 4 to 6 weeks	days	
<u>Cannabis</u>	3 to 7 days, up to >30 days after heavy use and/or in users with high body fat http://en.wikipedia.org/wiki/Drug_test_-_cite_note-ReferenceA-6#cite_note-ReferenceA-6	up to 90 days	2–3 days, up to 2 weeks in heavy users ^l
<u>Cocaine</u>	2 to 5 days with exceptions for certain kidney disorders	up to 90 days	2 to 5 days
<u>Codeine</u>	2 to 3 days		
<u>Cotinine (a breakdown product of nicotine)</u>	2 to 4 days	up to 90 days	2 to 4 days
<u>Morphine</u>	2 to 4 days	up to 90 days	1 – 3 days
<u>Heroin</u>	3 to 4 days	up to 90 days	1– 2 days
<u>LSD</u>	24 to 72 hours (however tests for LSD are very uncommon)	up to 3 days	0 to 3 hours
<u>Methadone</u>	3 days	up to 97 days	24 hours

<u>PCP</u>	3 to 7 days for single use; up to 30 days in chronic users	up to 90 days	1 to 3 days
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(LabCorps)

SECTION THREE: CPS LOGISTICAL INFORMATION

1. Court schedule
2. Automated complaint distribution process

COURT SCHEDULE: DAYTIME REMOVALS

[REMOVALS BETWEEN 11:00 AM AND 11:59 PM]

REMOVAL DAY	COMPLAINT FILED IN COURT/ GAL APPOINTED	PAPERING/11:00 AM INITIAL HEARING
Monday	Tuesday	Thursday
Tuesday	Wednesday	Friday
Wednesday	Thursday	Saturday
Thursday	Friday	Monday
Friday	Saturday	Monday
Saturday	Monday	Tuesday
Sunday	Monday	Wednesday

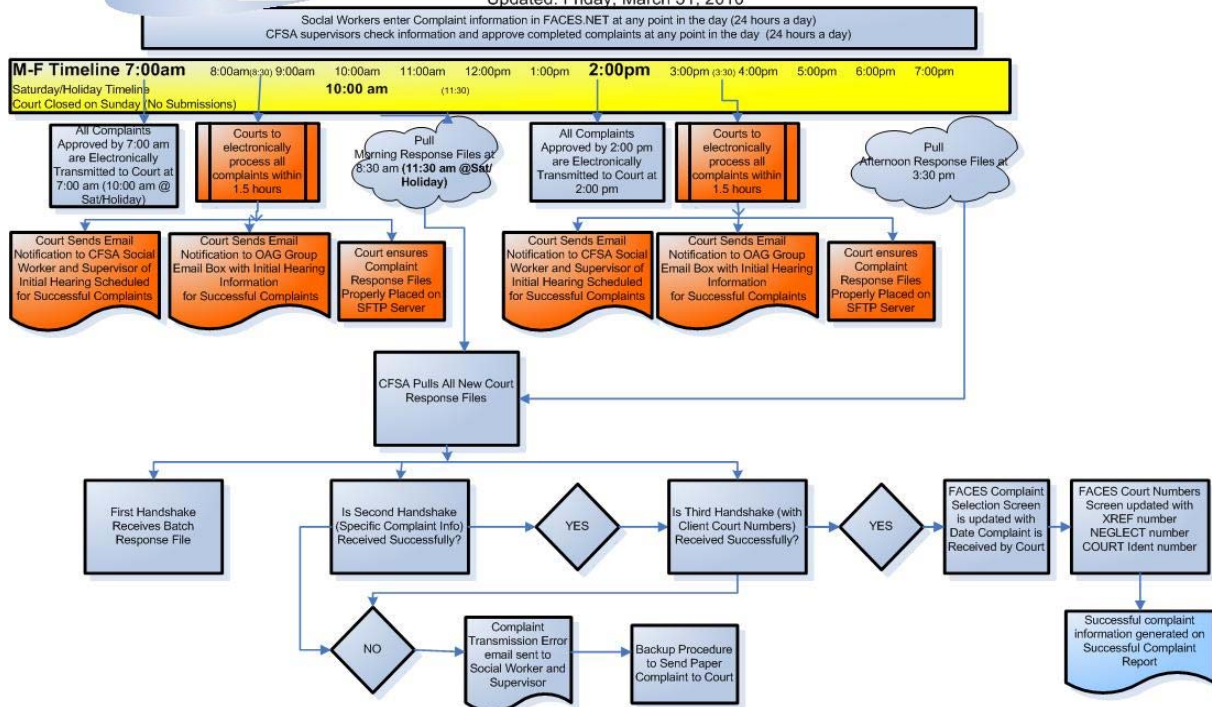
COURT SCHEDULE: MIDNIGHT REMOVALS

[REMOVALS BETWEEN MIDNIGHT AND 10:59 AM]

REMOVAL DAY/COMPLAINT EMAILED TO COURT/GAL APPOINTED	COMPLAINT FILED IN COURT	PAPERING/11:00 AM INITIAL HEARING
Monday	Tuesday	Wednesday
Tuesday	Wednesday	Thursday
Wednesday	Thursday	Friday
Thursday	Friday	Saturday
Friday	Saturday	Monday
Saturday	Monday	Monday
Sunday	Monday	Tuesday

CFSA/DCSC Automated Complaint Transmission Process

Updated: Friday, March 31, 2010



Key

CFSA – Child and Family Services Agency

DCSC – District of Columbia Superior Court/Family Court

Timeline

Assumptions: If errors occur in handshake 2 or 3, erroneous complaint can not be restarted automatically.

If response files not found on SFTP server within 1.5 hours after submission, error email is sent and complaint must be delivered manually.

SECTION THREE: CPS PRACTICE POINTS

1. Minimal Basic Needs of Children
2. Interviewing Children
3. Interviewing the Survivor of DV
4. Interviewing Children Exposed to DV
5. Guidelines for Interviewing Abusive Partners

CPS PRACTICE POINTS



Minimal Basic Needs of Children

adapted from the Research Foundation of SUNY- Center for Development of Human Services

The minimal basic needs of children are very much the same as the minimal basic needs of an adult, some of which may seem to be plain “common sense”. Nonetheless, as the CPS social worker, you should familiarize yourself with the list below, and recognize that these standards are provided as guidance only. Every standard DOES NOT have to be met for you to have concerns about a child’s safety or for you to provide support and/or intervention. You will have to make assessments on a case-by-case basis for whether families are promoting their children's safety and healthy development through provision of minimal basic needs: food and nutrition, clothing, shelter, hygiene and cleanliness, medical care, supervision, and/or discipline.

MEDICAL CARE	
Minimal Standards	Actual/Potential harm to the Child
<p>Adequate treatment sought for serious/acute illnesses or injuries.</p> <p>Standardized routine health care provided, including dental, psychiatric and optometric.</p> <p>Attention to recommended follow-up medical and dental appointments.</p> <p>Required medications and other treatments</p>	<p>Child May:</p> <p>Suffer acute or chronic illness/injury ;</p> <p>Experience long-term disability or loss of function due to untreated or improperly treated illness or injury;</p> <p>Be unable to attend school regularly, impairing social, emotional, mental</p>

provided.	development; Die.
SUPERVISION	
Minimal Standards	Actual/Potential harm to the Child
<p>Supervision will be adequate for the child based on age and developmental level.</p> <p>Infants and toddlers will be supervised at all times by someone capable of meeting their needs and keeping them safe.</p> <p>Older children will be supervised at a level commensurate with their age, developmental level, behavior, and temperament to make sure they are not engaging in hazardous behavior or are in a hazardous situation.</p> <p>Children will not supervise other children they are developmentally incapable of caring for or keeping safe; supervision will be structured in that the children will be expected to be in school when required and not roaming the streets unsupervised late at night.</p> <p>Supervision will be provided by someone capable of providing the level of care required (for example, not under the influence of drugs or alcohol to the extent that they are incapable of providing the level of supervision required, not physically or mentally infirm to the point that they are incapable of providing the level of supervision required.)</p>	<p>Child May</p> <p>Experience acute or chronic illness or injury;</p> <p>Engage in truancy or delinquent behavior;</p> <p>Sexually exploited, abducted, abandoned;</p> <p>Die.</p>

DISCIPLINE	
Minimal Standards	Actual/Potential harm to the Child
<p>Caretakers will discipline their children commensurate with the child's age.</p> <p>Developmental level, physical and mental condition and capacity to understand the intent of the discipline.</p> <p>Discipline should not go beyond what is objectively reasonable.</p> <p>Discipline may include corporal punishment; however, the corporal punishment should not be excessive.</p> <p>The following questions can help to determine the appropriateness of discipline:</p> <p>Does the child understand why he or she is being punished?</p> <p>Is the level of punishment commensurate with the misbehavior?</p> <p>Is the means of punishment appropriate to correct the behavior?</p> <p>Are less severe alternatives available?</p> <p>What is the nature of the punishment? (It should not be brutal, degrading, and sexual in nature or beyond the child's level of endurance; nor should the discipline seriously injure the child or put the child at risk of serious injury.)</p>	<p>Child May</p> <p>Suffer serious physical injury or risk of serious physical injury;</p> <p>Become disabled long-term or permanently lose functioning or risk loss thereof;</p> <p>Become mentally impaired or risk impairment;</p> <p>Die;</p> <p>Suffer long-term emotional trauma, poor self-concept.</p>
CLOTHING	
Minimal Standards	Actual/Potential harm to the Child
Free from filth, parasites, and foul odors.	Child May

<p>Big enough to fit adequately.</p> <p>Capable of providing protection from harsh weather, including footwear.</p> <p>Covers private parts of the body.</p>	<p>Suffer acute or chronic illness/injury (scabies, frostbite);</p> <p>Be ostracized by peers, resulting in damaged self-concept;</p> <p>Avoid school or be suspended;</p> <p>Adopt delinquent behaviors (shoplifting) to obtain other clothing</p> <p>Be sexually exploited.</p>
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FOOD & NUTRITION

Minimal Standards	Actual/Potential harm to the Child
<p>Provision of food that meets established nutritional requirements for physical and mental development and basic energy needs.</p> <p>Sufficient quantity to regularly meet nutritional needs, including fluid intake.</p> <p>Feeding assistance based on developmental or other needs as appropriate.</p> <p>Hygienically safe preparation and storage of foods.</p>	<p>Child may</p> <ul style="list-style-type: none"> ➤ Experience acute or chronic illness, weight loss, vitamin deficiency, disease, injury, developmental delays, loss of function or disability; ➤ Die; ➤ Feel unloved due to unmet needs; ➤ Adopt delinquent behaviors (stealing food) in order to get needs met.

HYGIENE AND CLEANLINESS

Minimal Standards	Actual/Potential harm to the Child
<p>Developmentally appropriate training in personal care.</p> <p>Regular bathing to keep skin free of reaches, infections, foul odors, parasites, sores, urine, fecal matter.</p>	<p>Child May</p> <p>Suffer acute or chronic illness/infection/infestation;</p> <p>Suffer from peer or societal ostracism;</p> <p>Suffer damaged self-esteem;</p>

<p>Hair free of parasites.</p> <p>Attention to dental hygiene.</p> <p>Opportunity to attend to hygiene and grooming as culturally appropriate.</p>	<p>May be suspended from school;</p> <p>Suffer impeded social and emotional development.</p>
SHELTER	
Minimal Standards	Actual/Potential harm to the Child
<p>Shelter that provides basic safety (no collapsing ceilings or obvious fire hazards).</p> <p>Sanitation (a way to adequately dispose of waste products, freedom from vermin).</p> <p>Access to water.</p> <p>Protection from the elements</p>	<p>Child May</p> <p>Die;</p> <p>Experience acute or chronic disease/illness/injury, social ostracism, and poor self-concept.</p>



CPS PRACTICE POINTS



Interviewing Children

Each child that you encounter through your work at CFSA is unique, reflecting the progress of his or her internal developmental clock and the influences of his or her family, environment, and resources. As part of your CPS response, you need to be skillful at interviewing children in a manner that is sensitive to their developmental stage, in order to develop an accurate understanding of their situation and their needs.

- Interview children in a safe, comfortable and neutral environment. Ensure you are at eye level with the child.
- Explain to the child why you are there. Explain in general terms the purpose of the interview.
- Smile a lot and affirm the child's contribution (e.g., "that's very important information" or "you are very helpful").
- Never rush an interview with a child. You should build rapport with the child before launching into the interview.
- Take as much time as the child needs to share information comfortably.
- Questions should progress from open-ended to specific.
- Use age appropriate language. Ask the child to explain what they mean by any word used that you do not understand.
- Discuss the importance of telling the truth in a way that is developmentally appropriate for the child's level.
- Gently explore discrepancies by asking for additional information.
- Always thank the child for taking time to speak with you.

When concluding the interview:

- Ask the child if there is anything else you need to know.
- Ask the child if they have questions for you.
- Explain to the child what will happen next in the investigation.



CPS PRACTICE POINTS


INTERVIEWING THE SURVIVOR OF DOMESTIC VIOLENCE

The following guidelines can help you obtain information that may help assess concerns related to child safety and domestic violence. Keep in mind what the victim may be experiencing and how difficult it is to share and seek help.

- Always conduct the interview privately.
- Determine the survivor's relationship with the abusive partner.
- Never share the survivor's responses with anyone, including close family members and especially not with the suspected batterer!
- *Be mindful that domestic violence survivors frequently fear disclosure based on past experiences with retaliation. They may also fear removal of their children as a result of the risk factors associated with domestic violence.*
- Reinforce the survivor's right to protect themselves and their children.
- Reassure the survivor that they are not alone in their struggle for safety and protection *but they must be strong enough to work with you, and the DV specialist, to develop a safety plan, to follow it, and to take advantage of available services.*
- Redirect any tendency on the part of the survivor to take blame for the violence.

ASK:

- Has your partner prevented you from going to work, school and/or place of worship?
- Has your partner acted jealously, or accused you of being unfaithful, or followed (stalked) you?
- Has your partner ever made you feel unsafe or afraid?
- Has your partner threatened self-injury if you didn't comply with a request? Threaten to injure or kill you, or other family members?
- Has your partner ever physically hurt you, leaving marks, bruises, welts, bleeding, fractures, etc.? (If necessary, use concrete action verbs, e.g., hit, slap, kick, punch, choke, burn, forced sex, etc.)
- Has your partner threatened to hurt, kill or remove the children from the home?
- Have your children witnessed your partner hurting you?

- Has your partner hit your child(ren) with belts, straps, hand or other objects that have resulted in marks, bruises, welts, or other serious injuries?
 - Has your partner assaulted you while you were holding your child?
 - Have you ever left home to protect yourself and your children?
 - Have you ever asked the abuser to leave home?
 - Have you asked anyone for help (e.g., family, friends, police, social worker, court, clergy, or other individuals)?
 - Do you have a plan in place for your safety right now?
 - What do you believe will keep you and your children safe?
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CPS PRACTICE POINTS

INTERVIEWING CHILDREN EXPOSED TO DOMESTIC VIOLENCE

The following questions will help you gain relevant information during an interview with children. As noted in the detailed section on domestic violence, many types of relationships can be involved in domestic violence. It is up to you as the CPS investigator to phrase the question according to the known relationship between the abuser, the survivor, and the child (e.g., mother and father, mother and mother's boyfriend, other adult relatives in the home, etc.).

Assess the pattern and extent of domestic violence.

- How often do the adults fight?
- What happens when they fight?
- Does anyone hit, shove, or push the other?
- Does anyone yell?
- Does anyone throw or break things?
- Has anyone ever used a gun or a knife? (Include knives that might not be used in the kitchen, e.g., a switchblade,)
- Have the police ever come to your home because of a fight?
- Tell me about the last big fight between the adults?

Assess the impact on the adult survivor.

- Has either adult been hurt or injured during the fighting? What did the injury look like to you?
- Is one of the adults afraid of the other?
- How do the adults act after a bad fight?
- Have you seen damaged property because of their fights?

Assess the exposure and impact of the domestic violence on the children.


- Have you ever been hurt during any of the adults' fights?
- What do your brothers and sisters do during a fight?
- Are you ever afraid for yourself or for one of the adults when the adults fight?
- Do you want to protect anyone during or after fighting?

- Have you ever tried to stop a fight? What happened?
- How do you feel during the fight? After the fight?
- Have you ever been made to take sides when the adults are fighting?
- Do you worry about the violence?
- Do you talk to anyone about the fights?
- Do you feel safe at home? If not, what specifically happens to make you feel unsafe?
- Do you sleep well at night? Have you ever had an accident (bedwetting) in the middle of the night?
- Have you ever been in a fight? Was anyone hurt?
- Have you ever felt like hurting yourself or someone else?

Assess any factors that promote the children's protection.

- Where do you go when your parents fight?
- If one of your parents or you or your siblings got hurt, what would you do?
Is there someone special you would call for help?
- Have you ever called for help before? What happened?
- Have any of the adults tried to protect you during a fight?

Assess the child's knowledge of and experience with danger.

- Has anyone threatened to hurt someone? What did the person say or do?
 - Has anyone needed to go to a doctor after a fight? Did they go right away?
 - Have you ever seen a gun or a knife that isn't from the kitchen? Have the adults used guns or special knives?
 - Has anyone ever called 911 during a fight?
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CPS PRACTICE POINTS

Guidelines for Interviewing Abusive Partners

The following guidelines for interviewing the alleged or confirmed abuser will help you determine the extent to which children and/or the survivor are in need of immediate help. Remember that domestic violence occurs between many varied relationships. The alleged abuser is not always the husband or the father, or the boyfriend. You must use the information you have in front of you as a result of your investigation to phrase the questions according to the actual relationship between the abuser and the survivor of abuse.

1. Conduct the interview privately.
2. Do not share any information with the abusive partner regarding other interviews, i.e., the survivor's responses to interview questions or descriptions from the children in the home, etc.
3. If the abusive partner poses an immediate danger to the survivor or to any child(ren), delay the interview until you have determined through an adequate assessment process that it is safe to do so.
4. If you have any reason whatsoever to suspect that the abusive partner poses a potential danger to you as the CPS worker, do not conduct the interview without first consulting the CPS management team and the DV specialist for strategies to protect your safety, e.g., arranging to interview at CFSA and/or requesting that a Metropolitan Police Department (MPD) officer be present at an MPD precinct.
5. During the interview, take the following precautions:
 - Trust your first instincts: if you feel afraid, you may be unsafe. Postpone the interview until your safety needs can be met.
 - Maintain a calm and professional attitude: the abusive partner may try to test your limits.
 - Do not engage in confrontational behavior with the abusive partner, or use language that might be judgmental.
 - Use empathetic statements, e.g., "I understand this is a difficult time for you", or "I'm here to help you and your family", etc.

- If the abuser does become provocative or intimidating, use empathetic statements to end interview, e.g., "Would you feel better if I call you tomorrow and we can set up another time to continue our conversation?"
- 6. Always notify the survivor if you become aware of threats to the survivor or to the children's safety, or if you experience any escalating behavior or anger on the part of the abusive partner.
- 7. Clarify any vague, non-specific language by asking concrete questions, or asking for more details: e.g., if the abusive partner speaks about "getting angry," or "losing my temper," follow-up with clarifying questions, such as "And what happens when you lose your temper?" If the abusive partner states, "I get physical," you may ask, "Do you shake or grab your partner?"
- 8. Become familiar with excuses for violence:
 - Minimizing, e.g., "It's only happened once or twice" or "It was just a push."
 - Citing good intentions, e.g., "I just wanted to be heard" or "I didn't mean to hurt anyone."
 - Blaming the violence on drugs or alcohol, e.g., "I only get upset when I've been drinking."
 - Blaming the violence on the partner or the children, e.g., "If my partner had only done what I asked, I wouldn't have had to strike out" or "Those kids make me so angry, if they would just stop interfering in our relationship, I wouldn't have to show them who's boss."
- 9. Discuss the District's definition of interpersonal violence, and explain that violence is any behavior that either forces the partner to do something they do not want to do or something that makes them afraid—including verbal threats, throwing things, etc.
- 10. Find out when the violence occurred and if possible, why it was directed at the partner.
- 11. Ask detailed questions about the last, first, and most serious incident. Use questions like, "Have there been other times when you have slapped your partner? How about the kids? How do you punish or discipline them? Have you had violent conflicts with co-workers or friends?"
- 12. Be direct and candid: often workers show their own discomfort with domestic violence and child abuse issues. It is important for you to be direct—it signals that it is okay for the abusive partner to talk to you about the violence. It helps the abusive partner see that there is a pattern that could possibly be changed. It also helps place responsibility for the violence on the abuser. Abusers frequently focus on the behavior of the person they're abusing. You can help shift the focus from the partner's behavior back onto the abuser's behavior, and help the abusive partner realize the harm that is being done by the violence.

